COVENTRY HEALTH CARE OF IOWA, INC.

HEALTH MAINTENANCE ORGANIZATION (HMO)

OPEN ACCESS (OA)

EVIDENCE OF COVERAGE

Welcome to Coventry Health Care of Iowa, Inc.!

We are extremely pleased to have You as a member of Our Health Plan and look forward to serving You. We have built a strong network of area Physicians, Hospitals, and other Providers to offer a broad range of services for Your medical needs.

As a Coventry Health Care of Iowa, Inc. Member, it is important that You understand the way Your Health Plan operates. This Evidence of Coverage contains the information You need to know about Your coverage with Us.

Please take a few minutes to read these materials and to make Your covered family members aware of the provisions of Your coverage. Our Customer Service Department is available to answer any questions You may have about Your coverage. You can reach them at (800) 257-4692 Monday through Friday, 8:00 a.m. to 6:00 p.m. Central Standard Time, or by logging on to Our website at www.chciowa.com.

We look forward to serving You and Your family.

Sincerely,

Michael Nelson

Chief Executive Officer

Coventry Health Care of Iowa, Inc.

Evidence of Coverage

The Agreement between Coventry Health Care of Iowa, Inc. (hereafter called "Health Plan", "We", "Us", or "Our") and You the Member is made up of:

- This Evidence of Coverage and any Amendments or Riders hereto;
- The Schedule of Benefits;
- Any Enrollment Form or Statement of Health You completed; and
- The Group Master Contract.

No person or entity has any authority to waive any Agreement provision or to make any changes or amendments to the Agreement unless approved in writing by an Officer of the Health Plan, and the resulting waiver, change, or amendment is attached to the Agreement. The Agreement begins on the date defined in the Group Master Contract. It continues, until replaced or terminated, while its conditions are met. You are subject to all terms, conditions, limitations, and exclusions in the Agreement and to all the rules and regulations of the Health Plan. By paying Premiums or having Premiums paid on Your behalf, You accept the provisions of the Agreement.

THIS EVIDENCE OF COVERAGE (EOC) SHOULD BE READ AND RE-READ IN ITS ENTIRETY.

Many of the provisions of this Evidence of Coverage are interrelated; therefore, reading just one (1) or two (2) provisions may give You a misleading impression. Many words used in this Evidence of Coverage have special meanings. These words will appear capitalized and are defined for You. By using these definitions, You will have a clearer understanding of Your coverage.

From time to time, the Agreement may be amended. When that occurs, We will provide an Amendment or new Evidence of Coverage to You. You should keep this document in a safe place for Your future reference.

Coventry Health Care of Iowa, Inc.
4320 114th Street
Urbandale, IA 50322
(800) 257-4692

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SECTION 1: DEFINITIONS

Any capitalized terms listed in this Section will have the meaning set forth below whenever the capitalized term is used in the Agreement. Any singular word will have the same meaning as any plural of the same word.

1.1 "Actively-at-Work"

The employment status required to be eligible for Coverage as defined by the Group Master Contract.

1.2 "Adverse Benefit Determination"

1.2.1 A utilization review determination by Us that, based upon the information provided, an admission, availability of care, continued stay, or other health care service does not meet Our requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested health care service is therefore denied, reduced, or terminated and payment is not provided or made in whole or in part; or

1.2.2 A denial, reduction, termination, or failure to provide or make payment in whole or in part, for a benefit based on a determination by Us of Your eligibility for Coverage by the Health Plan.

1.3 "Agreement"

This Evidence of Coverage and Amendments, the Enrollment Form, the Schedule of Benefits, applicable Riders, and the Group Master Contract together form the Agreement.

1.4 "Allowable Amount"

This is the maximum amount the Health Plan has determined is eligible for payment for each Covered Service, before any Deductible, Copayments, Coinsurance or penalties are applied.

For In-Network services this is the amount Participating Providers have contractually agreed to accept as payment for Covered Services they provide to Health Plan Members. It is from this amount that any Deductible, Copayments, Coinsurance and penalties are deducted prior to issuing payment. Participating Providers are not permitted to bill You for charges that exceed the Allowable Amount.

Out-of-Network Services are not Covered except for Emergency Services.

The Allowable Amount for Emergency Services received Out-of-Network will be the same as the In-Network rate.

1.5 "Amendment"

Any description of changes, additions or deletions to Covered Services that is attached to this Evidence of Coverage. Amendments are effective only when issued by the Plan and are subject to all conditions, limitations and exclusions in the Evidence of Coverage that are not specifically superseded by the Amendment. In the event of a conflict between the Evidence of Coverage and the Amendment, the Amendment will apply.

1.6 "Appeal"

An Appeal is a request by the Member or Member's Authorized Representative for consideration of an Adverse Benefit Determination.

1.7 "Authorized Representative"

An Authorized Representative is an individual authorized by the Member to act on the Member's behalf in obtaining claim payment or during the Appeal process. A Provider may act on behalf of a Member with the Member's express consent, or without the Member's express consent in emergent situations.

1.8 "Benefit Year"

The period during which the total amount of yearly benefits under Your Coverage is calculated. The applicable time period is indicated on Your Schedule of Benefits as either a contract year or calendar year. A contract year is the period of twelve (12) consecutive months commencing on the Group Effective Date and each subsequent anniversary. A calendar year is the period of twelve (12) consecutive months commencing on January 1st and continuing through December 31st of that year.

1.9 "Biologically Based Mental Illness"

The following psychiatric illnesses as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental

Disorders:

1.9.1 Schizophrenia;

1.9.2 Bipolar disorders;

1.9.3 Major depressive disorders;

1.9.4 Schizo-affective disorders;

1.9.5 Obsessive-compulsive disorders;

1.9.6 Pervasive developmental disorders; and

1.9.7 Autistic disorders.

1.10 "COBRA"

The Consolidated Omnibus Budget Reconciliation Act, as amended.

1.11 "Coinsurance"

Coinsurance means the amount, calculated using a percentage, that You are responsible for paying when You receive certain Covered Services. The percentage amount is calculated as a percentage of the Allowable Amount after any Deductible, Copayment, or penalties have been deducted.

1.12 "Complaint"

Any expression of dissatisfaction expressed by a Member or Member's Authorized Representative regarding Coverage that does not rise to the level of an Appeal.

1.13 "Convenient Care Clinic"

A medical clinic located in a retail location including, but not limited to, a grocery or drug store, where a Provider offers treatment of minor medical conditions, immunizations, and physicals without an appointment.

1.14 "Copayment"

A specified dollar amount You must pay as a condition of the receipt of certain services as provided in the Schedule of Benefits. The Copayment may be collected directly by the Provider at the time of service.

1.15 "Cosmetic"

A procedure, service, surgery or supply:

1.15.1 From which no significant improvements in physiologic function could be reasonably expected;

1.15.2 That does not meaningfully promote the proper function of the body or prevent or treat illness or disease; or

1.15.3 Done primarily to improve the appearance or diminish an undesired appearance of any portion of the body.

Surgery performed solely to address psychological or emotional factors is considered Cosmetic.

1.16 "Coventry Approved Transplant Facility"

A facility that has a contract with the Health Plan and is designated as a Center of Excellence for particular transplants.

1.17 "Cover" or "Covered" or "Coverage"

The entitlement of a Member to Covered Services or a particular Covered Service as provided under the Agreement, and subject to all terms, conditions, limitations and exclusions of the Agreement, including the following conditions:

1.17.1 Health services, treatment, and devices must be provided after the Member's Effective Date to be Covered;

1.17.2 Health services, treatment, and devices must be provided prior to the date that any of the termination conditions listed under the Agreement occur, including, but not limited to termination of the Group Master Contract or termination of the Member's Coverage;

1.17.3 Health services, treatment, and devices must be provided only when the recipient meets all eligibility

requirements specified in the Agreement, regardless of whether the Member or Group has submitted a Change Form or terminated Coverage;

1.17.4 Health services, treatment, and devices must be determined Medically Necessary by Us; and

1.17.5 Health services, treatment, and devices listed as "Covered Services" in the Agreement.

1.18 "Covered Individual"

Any Member who meets the eligibility requirements described in the Agreement and is enrolled for Coverage in accordance with the terms and conditions of the Agreement. Please refer to the definition of "Member."

1.19 "Covered Services/Covered Service"

Medically Necessary services or supplies provided to You for which the Health Plan will make payment, as described in the Agreement.

1.20 "Deductible"

The amount You must pay for Covered Services each Benefit Year before benefits are payable by Us. This amount, if applicable, is listed in Your Schedule of Benefits. See also definitions of "Family Deductible" and "Individual Deductible".

1.21 "Dependent"

Any member of a Subscriber's family who meets the eligibility requirements and who is properly enrolled for Coverage under the Agreement and on whose behalf Premiums are paid.

1.22 "Durable Medical Equipment ("DME")"

Medical equipment Covered under the Agreement, which can withstand repeated use and is not disposable, is used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury, and is appropriate for use in the home, including Medically Necessary, non-disposable accessories that are commonly associated with the use of a Covered piece of Durable Medical Equipment.

1.23 "Effective Date/Member Effective Date"

The date entered on Our records as the date when Coverage for a Member under the Agreement begins. Coverage will take effect at 12:01 a.m. on the date required under the terms of the Agreement.

1.24 "Emergency Medical Condition/Emergency"

Emergency Medical Condition means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including, but not limited to, severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

1.24.1 Serious jeopardy to the health of the individual (or unborn child) or in the case of a behavioral condition, placing the health of the individual or others in serious jeopardy;

1.24.2 Serious impairment to any bodily functions;

1.24.3 Serious impairment to any bodily organ or part; or

1.24.4 Serious disfigurement.

1.25 "Emergency Services"

Covered inpatient and outpatient services that are:

1.25.1 Provided by a Provider qualified to provide treatment of an Emergency Medical Condition; and

1.25.2 Necessary to evaluate or stabilize an Emergency Medical Condition.

1.26 "Employee"

A person who receives compensation from the Group for work performed for the Group. An Employee will not include a person who is unauthorized to work in the United States pursuant to the Immigration and Nationality Act and related rules and regulations.

1.27 "Enrollment Form, Enrollment/Change Form, and/or Statement of Health"

Your application for enrollment in the Health Plan.

1.28 "Essential Health Benefits"

Essential Health Benefits are those benefits defined in Section 1302(b) of the Patient Protection and Affordable Coverage Act (PPACA) and regulations issued by the United States Department of Human Services. Essential benefits are those benefits that the Health Plan, pursuant to PPACA, deems to fall within the following categories: ambulatory patient services, emergency services, hospitalization, newborn care, prescription drugs, if Covered under the Agreement or an attached Rider, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including certain oral and vision care, as described in Section 8.1 - Table of Covered Services.

1.29 "Experimental or Investigational"

A health product or service is deemed experimental or investigational if one or more of the following conditions are met:

1.29.1 Any drug not approved for use by the Food and Drug Administration (FDA); any FDA approved drug prescribed for an off-label use whose effectiveness is unproven based on clinical evidence reported in Peer-Reviewed Medical Literature; or any drug that is classified as investigational new drug (IND) by the FDA. As used herein, off-label prescribing means prescribing prescription drugs for treatments other than those stated in the labeling approved by the FDA;

1.29.2 Any health product or service that is subject to Institutional Review Board (IRB) review or approval;

1.29.3 Any health product or service that is the subject of a clinical trial that meets criteria for Phase I, II or III as set forth by FDA regulations; or

1.29.4 Any health product or service whose effectiveness is unproven based on clinical evidence reported in Peer-Reviewed Medical Literature.

Although a service, supply, equipment, drug or procedure is approved for a diagnosis, disorder or condition, it may be considered Experimental or Investigational for a different diagnosis, disorder or condition and therefore be excluded from Coverage.

1.30 "Family Deductible"

This plan has a traditional/embedded Deductible. The Family Deductible is the amount that must be paid for Covered Services each Benefit Year by Members of a family before benefits will be payable by the Health Plan. The Family Deductible is satisfied when the expenses for any combination of Members in a family equals the Family Deductible amount. However, no family member may satisfy more than the Individual Deductible dollar amount towards the Family Deductible Amount. For example, if there are only two (2) Members in a family and each satisfy the Individual Deductible, the Family Deductible is considered satisfied. The Family Deductible and Individual Deductible are listed on the Schedule of Benefits.

1.31 "Full-Time Student"

An individual who is enrolled and attending, full-time, a recognized course of study or training at:

1.31.1 An accredited high school or vocational school;

1.31.2 An accredited college or university; or

1.31.3 A licensed technical school, beautician school, automotive school, or similar training school.

Full-Time Student status is determined in accordance with the standards set forth by the educational institution and includes periods of scheduled vacation or breaks established by the educational institution as long as the individual continues at full-time status following the break. A student is no longer considered a Full-Time Student at the end of the month of graduation or when full-time enrollment ceases.

1.32 "Grievance"

A written Complaint, or an oral Complaint if the Complaint involves an Urgent Care request, submitted by or on behalf of a Member regarding any aspect of the Health Plan, relative to the Member, including, but not limited to:

1.32.1 Availability, delivery, or quality of health care services, including a Complaint regarding an adverse determination made pursuant to utilization review;

1.32.2 Claims payment, handling, or reimbursement for health care services; or

1.32.3 Matters pertaining to the contractual relationship between a covered person and a health carrier.

1.33 "Group"

An organization or firm contracting with the Health Plan to arrange health care services for their Employees, and through which eligible Subscribers and Dependents enroll and become entitled to the benefits described herein.

1.34 "Group Master Contract"

The agreement between the Group and Us that states the agreed upon contractual rights and obligations of the Health Plan, the Group, and Members, and that describes the costs, procedures, conditions, limitations, exclusions, and other obligations afforded to Members.

1.35 "Group Effective Date"

The date that is specified in the Group Master Contract as the effective date of the Agreement.

1.36 "Group Enrollment Period"

Will mean a period of time occurring at least once annually during which time any eligible Employee and Dependents may enroll with the Health Plan for Coverage under this Evidence of Coverage.

1.37 "Health Plan"

Coventry Health Care of Iowa, Inc (the Health Plan).

1.38 "High Technology Diagnostics"

Highly developed technologies that use computerized imaging or radio isotropic enhancements to play a decisive role in diagnostics which include, but are not limited to, procedures as defined by Us, including, but not limited to, ultrafast computed tomography (UFCT), magnetic resonance imaging (MRIs), magnetic resonance angiogram (MRAs), computerized tomography scan (CT Scans), positron emission tomography scan (PET Scans), single photon emission computed tomography scan (SPECT Scans), some types of ultrasounds and other nuclear radiology.

1.39 "Hospital"

An institution, operated pursuant to law, which:

1.39.1 Is primarily engaged in providing health services for the care and treatment of injured or sick individuals through medical, diagnostic and surgical facilities by or under the supervision of one or more Physicians;

1.39.2 Has twenty-four (24) hour nursing services on duty; and

1.39.3 Is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Hospital Association, or certified under Title XVIII of the Social Security Act (the Medicare program).

A facility that is primarily a place for rest, custodial care or care of the aged, a nursing home, convalescent home, or similar institution is not a Hospital.

1.40 "Individual Deductible"

The amount an individual Member must pay for Covered Services each Benefit Year before benefits are payable by the Health Plan.

1.41 "Infertility"

Infertility means the inability of an individual to conceive a pregnancy or produce conception after one (1) year of unprotected intercourse between a man and a woman or the inability of a woman to carry a pregnancy to live birth.

1.42 "In-Network"

Any Provider who has entered into a written agreement with Us to provide health services to Members. See also "Participating Provider", definition 1.55.

1.43 "Inquiry"

Any question from a Member or Member's Authorized Representative regarding Coverage that does not rise to the level of an Appeal (e.g., benefits information, claim status, or eligibility).

1.44 "Jaw Joint Disorder"

Includes temporomandibular joint disorder and craniomandibular disorder. It does not include a fracture or dislocation which results from an injury, any misalignment, dysfunction or other disorder of the jaw joint (or of the complex of muscles, nerves and tissues related to that joint).

1.45 "Limiting Age"

The maximum age a non-Spouse Dependent attains and still maintains eligibility under the terms of the Agreement. The Limiting Age is as provided in the Evidence of Coverage, unless an older age is agreed upon in the Group Master Contract.

1.46 "Medical Director"

The Physician specified by Us as the Medical Director or other Health Plan staff designated to act for, under the general guidance of, and in consultation with the Medical Director.

1.47 "Medically Necessary/Medical Necessity"

Medically Necessary means those services, supplies, equipment and facilities charges that are not expressly excluded under the Agreement and determined by Us to be:

1.47.1 Medically appropriate, so that expected health benefits (including, but not limited to, increased life expectancy, improved functional capacity, prevention of complications, relief of pain) more than marginally exceed the expected health risks*;*

1.47.2 Necessary to improve Your health, physiological function and required for a reason other than improving appearance;

1.47.3 Provided in the most cost-efficient manner and setting appropriate for the delivery of the health service, without compromising the quality of care;

1.47.4 Consistent in type, frequency and duration of treatment with scientifically-based guidelines of national medical research, professional medical specialty organizations or governmental agencies that are generally accepted as national authorities on the services, supplies, equipment or facilities for which Coverage is requested;

1.47.5 Consistent with the diagnosis of the condition at issue;

1.47.6 Required for reasons other than Your comfort or the comfort and convenience of Your Physician;

1.47.7 Of demonstrated value based on clinical evidence reported by Peer-Reviewed Medical Literature and by generally accepted academic medical experts; that is, it is not Experimental or Investigational;

1.47.8 Not Experimental or Investigational as determined by Us under Our Experimental Procedures Determination Policy. (A copy of the Experimental Procedures Determination Policy is available upon request from Our Member Services Department.); and

1.47.9 Necessary to meet the basic health needs of the Member as a minimum requirement.

Please note: Although a service, supply, equipment, drug or procedure is approved for a diagnosis, disorder or condition, it may be considered Experimental or Investigational for a different diagnosis, disorder or condition and therefore be excluded from Coverage.

1.48 "Member"

Any Subscriber, Dependent or Qualified Beneficiary (as the term is defined under COBRA) who is enrolled for Coverage in accordance with the terms and conditions of the Agreement.

1.49 "Member Cost Share"

Member Cost Share means the portion of health care costs a Member is responsible for paying each Benefit Year when Covered Services are received from a Provider, including, but not limited to, any Copayments, Deductibles, and

Coinsurance amounts listed on Your Schedule of Benefits. Please refer to Section 6.7, Member Responsibility of this Evidence of Coverage.

1.50 "Mental Disorder"

A clinically significant syndrome or pattern that falls under a diagnostic category listed in the most recent Diagnostic and Statistical Manual of Mental Disorders. Some conditions are not Covered. Please refer to the Exclusions and Limitations Section.

1.51 "Non-Participating Provider/Non-Participating"

A Provider who has no written agreement with Us to provide health services to Members.

1.52 "Officer"

The person holding the office of President and/or CEO of the Health Plan or his or her designee.

1.53 "Out-of-Network"

Any Provider who is Non-Participating, because they have not entered into a written agreement with Us to provide health services to Members.

1.54 "Out-of-Pocket Maximum"

The individual Out-of-Pocket Maximum is a limit on the amount a Member must pay out of his or her pocket for Covered Services in a Benefit Year. The family Out-of-Pocket Maximum is the limit on the total amount Members of the same family Covered under the Agreement must pay for specified Covered Services in a Benefit Year. Penalties and expenses for non-Covered Services do not apply to the Out-of-Pocket Maximum. Individual and Family Out-of-Pocket Maximum amounts and descriptions are listed in the Schedule of Benefits. Copayments do not apply to the Out-of-Pocket Maximum unless specified in the Schedule of Benefits.

1.55 "Participating Provider/Participating"

A Provider who has entered into a written agreement with Us to provide health services to Members. "Participating" refers only to those Providers included in the network of Providers described in the provider directory. The participation status of Providers may change from time to time.

1.56 "Patient Costs"

In the context of a clinical trial, any fee or expense that is Covered and is for a service or treatment that would be required if the Covered Person were receiving usual or customary care. Patient cost does not include the cost:

1.56.1 Of any drug or device provided in a phase I cancer clinical trial;

1.56.2 Of any investigational drug or device;

1.56.3 Of nonhealth services that might be required for a Covered Person to receive treatment or intervention;

1.56.4 Of managing the research of the clinical trial;

1.56.5 That would not be covered under the Plan.

1.57 "Peer-Reviewed Medical Literature"

A phrase that is defined by two elements:

1.57.1 It refers to the requirement that medical literature on a topic is only considered relevant if it is a scientific study, which has been published in the English language (mostly American) only after review by academic experts for structure of study and validity of conclusions, prior to acceptance for publication; and

1.57.2 Based on a methodology used by certain authoritative bodies (including The National Cancer Institute PDQ Guidelines for Cancer Treatment and the International Consensus Conference on Bone Marrow Transplantation), the medical literature is graded for its quality using a 2-by-2 grid based on two parameters: strength of the evidence and effectiveness.

1.57.2.1 Strength of evidence is graded from the highest level of evidence to the lowest, as follows:

1.57.2.1.1 Level 1: Randomized, controlled trial;

1.57.2.1.2 Level 2: Cohort/Case Control Study;

1.57.2.1.3 Level 3: Systematic Literature Review;

1.57.2.1.4 Level 4: Large consecutive case series;

1.57.2.1.5 Level 5: Small consecutive case series;

1.57.2.1.6 Level 6: Textbook chapters (opinion of a respected authority);

1.57.2.1.7 Level 7: Case report.

1.57.2.2 Effectiveness is evaluated using 4 measurements:

1.57.2.2.1 Is the proposed treatment harmful or beneficial?

1.57.2.2.2 Do the results favor the study (experimental) group or the control group?

1.57.2.2.3 Is the outcome considered statistically week or strong?

1.57.2.2.4 Is the study design weak or strong?

1.58 "Physician"

Any Doctor of Medicine, "M.D.", or Doctor of Osteopathy, "D.O.", who is duly licensed and qualified under the law of the jurisdiction in which treatment is received. Physician does not include an immediate relative of a Member unless otherwise required by state law.

1.59 "Premium"

The monthly fee required to be paid on behalf of each Member in accordance with the terms of the Group Master Contract.

1.60 "Preventive" or "Preventive Services"

Preventive Services are services that focus on the prevention of disease and health maintenance, including the early diagnosis of disease, discovery and identification of high risk for specific problems, and interventions to avert a health problem in non-symptomatic individuals, including:

1.60.1 Evidence-based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force (with respect to breast cancer screening, mammography, and prevention, the USPSTF recommendations from November 2009 will not be included/considered);

1.60.2 Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;

1.60.3 With respect to infants, children and adolescents, evidence-informed preventive care and screening provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

1.60.4 With respect to women, such additional preventive care and screenings not described in 1.60.1 as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Please Note: Cost-sharing, including Coinsurance, Copayments and Deductibles, are not applicable to specified Preventive Services. Please refer to the Covered Services Section and Schedule of Benefits for a list of Preventive Services Covered under the Agreement.

1.61 "Prior Authorization/Authorization/Authorized"

Verification of Medical Necessity by the Health Plan, for certain services, supplies, equipment, drugs or procedures to be received by a Member. Authorization does not guarantee payment if You are not eligible for Covered Services at the time the service is provided or it is not a Covered Service.

1.62 "Primary Care Physician ("PCP")"

This is the Participating Physician who practices in the fields of Internal or General Medicine, Family Practice, Obstetrics and Gynecology, or Pediatrics who is designated as a PCP by Us.

1.63 "Provider"

A Physician, Hospital, skilled nursing facility, home health agency, hospice, pharmacy, podiatrist, optometrist, chiropractor or other health care institution or practitioner, licensed, certified or otherwise authorized pursuant to the law of the jurisdiction in which care or treatment is received.

1.64 "Qualified Medical Child Support Order"

A medical child support order, issued by a court of competent jurisdiction or through an administrative process established under state law, which creates or recognizes the existence of a child or children's right to receive Coverage for which a Member is entitled in accordance with applicable state and federal laws. The valid order must be submitted to the Health Plan for a child to receive Coverage.

1.65 "Rider"

Any description attached to the Evidence of Coverage that modifies its benefits. Coverage provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when issued by the Health Plan and are subject to all conditions, limitations and exclusions in the Evidence of Coverage that are not specifically superseded by the Rider. In the event of a conflict between the Evidence of Coverage and the Rider, the Rider will apply.

1.66 "Self-Administered Injectables"

Injectable prescription drugs as specified in the Health Plan's formulary list that are commonly and customarily administered by the Member according to clinical guidelines used by the Health Plan.

1.67 "Service Area"

The geographic area served by the Health Plan as approved by the state of Iowa and shown on the Service Area description in this Evidence of Coverage. The Health Plan's Service Area is subject to change.

1.68 "Specialty Care Physician/Specialist"

A Physician who provides medical services to Members within the range of a medical specialty and who is not acting as a Primary Care Physician.

1.69 "Spouse"

A person to whom the Subscriber is validly married:

1.69.1 Under the law of the state in which the marriage was entered into; and

1.69.2 Recognized in the state where the Group is located.

A common law spouse qualifies as a Spouse under the Agreement only if his/her spousal status is affirmed by a court of competent jurisdiction.

However, when a benefit is governed solely by federal law that prohibits recognition of same sex marriage, same-sex spouses may not be Covered as a Spouse. Examples of benefits where Spouses cannot be of the same-sex as the Subscriber include, but are not limited to, COBRA continuation coverage and flexible spending accounts (FSAs), health reimbursement accounts (HRAs) or health savings accounts (HSAs).

1.70 "Subscriber"

The eligible Employee who has elected the Health Plan's Coverage through submission of an Enrollment/Change Form and for whom, or on whose behalf, Premiums have been received by the Health Plan.

1.71 "Substance-Related Disorder"

The psychological or physiological dependence upon and abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and impairment of social or occupational role functioning or both.

1.72 "Temporomandibular Joint Disorder ("TMJ")"

Please refer to the definition of "Jaw Joint Disorder."

1.73 "Therapeutic Injections and IV Infusions"

Prescription medications given by injection or IV infusion (specifically excluding blood) by a duly-licensed Provider.

1.74 "**Total Disability, Totally Disabled or Disabled"**

Complete inability of the Member to perform all of the substantial and material duties of his or her regular occupation, or complete inability of the Member to engage in employment or occupation for which he or she is or becomes qualified by reason of education, training, or experience. For an unemployed Dependent, Total Disability means complete inability of the Member to engage in most of the normal activities of a person of like age and gender. The disability, for Subscriber or Dependent, must require regular care and attendance by a Physician who is someone other than an immediate family member.

1.75 "Uniformed Services"

The United States Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency.

1.76 "Urgent Care"

Urgent Care is Medically Necessary care for an unexpected illness or injury that does not qualify as an Emergency Medical Condition but requires prompt medical attention.

1.77 "Urgent Care Appeal"

An Urgent Care Appeal is:

1.77.1 An Appeal that must be reviewed under an expedited appeal process because the application of non-Urgent Care Appeal time frames could seriously jeopardize:

1.77.1.1 The life or health of the Member; or

1.77.1.2 The Member's ability to regain maximum function.

In determining whether an Appeal involves Urgent Care, We will apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

1.77.2 An Urgent Care Appeal is also an Appeal involving:

1.77.2.1 Care that the treating Physician deems urgent in nature; or

1.77.2.2 The treating Physician determines that a delay in the care would subject the Member to severe pain that could not be adequately managed without the care or treatment that is being requested.

1.78 "Urgent Care Facility"

A facility specifically set up for Providers to offer Urgent Care on a walk-in basis, as an alternative to a Hospital or Emergency room or a Primary Care Physician or Specialist office visit.

1.79 "We/Us or Our"

The Health Plan.

1.80 "You/Your"

A Member covered under the Agreement.

SECTION 2: SUBSCRIBER ELIGIBILITY

2.1 Subscriber Eligibility

To be eligible for Coverage as a Subscriber an individual must:

2.1.1 Live or work in the Service Area at least nine (9) months out of the Benefit Year unless on temporary work assignment of six (6) months or less;

2.1.2 Be an Employee of the Group;

2.1.3 Meet any eligibility criteria specified in the Group Master Contract;

2.1.4 Complete and submit to the Health Plan such applications or forms the Health Plan may reasonably

request; and

2.1.5 Satisfy any waiting period provided by the Group Master Contract.

SECTION 3: DEPENDENT ELIGIBILITY

3.1 General Dependent Eligibility Requirements

To be eligible for Coverage as a Dependent, an individual must meet the following requirements:

3.1.1 Live in the Health Plan Service Area at least nine (9) months out of the year, unless eligible as a Full-Time Student or Covered under a Qualified Medical Child Support Order;

3.1.2 Meet any eligibility criteria specified in the Group Master Contract; and

3.1.3 Complete and submit to the Health Plan such applications or forms the Health Plan may reasonably request.

3.2 Eligible Dependents

In addition to meeting the General Dependent Eligibility Requirements listed above, an eligible Dependent is an individual who is one of the following:

3.2.1 The lawful Spouse of the Subscriber;

3.2.2 A child under the Limiting Age of twenty-six (26), or older if provided by the Group Master Contract:

3.2.2.1 Who is either the birth child of the Subscriber or the Subscriber's Spouse;

3.2.2.2 Who is legally adopted by or placed for adoption with the Subscriber or Subscriber's Spouse;

3.2.2.3 For whom the Subscriber or the Subscriber's Spouse is required to provide health care coverage pursuant to a Qualified Medical Child Support Order; or

3.2.2.1 For whom the Subscriber or the Subscriber's Spouse is the court appointed legal guardian.

3.2.3 An unmarried child of any age, if:

3.2.3.1 The child has a disability and as a result, they are physically or mentally incapable of earning a living and chiefly dependent on the Member for support and maintenance;

3.2.3.2 The onset of such incapacity occurred before the Limiting Age; and

3.2.3.3 Proof of such incapacity is furnished to Us by the Member upon enrollment or at the onset of the Dependent child's incapacity prior to reaching the Limiting Age and annually thereafter.

3.3 Eligible Dependents Who Have Reached the Limiting Age

If Coverage would otherwise terminate as a result of a Dependent reaching the Limiting Age in Section 3.2.2, coverage may be continued if the unmarried Dependent Member:

3.3.1 Is a Full-Time Student and maintains Full-Time Student status after reaching the Limiting Age;

3.3.2 Had Creditable Coverage, as defined below, during any periods where the child was not Covered by Us; and

3.3.3 Submits documentation of Full-Time Student status to the Health Plan upon request and at least twice annually.

NOTE: After an unmarried child reaches the Limiting Age of twenty-six (26), if the child ceases to be a Full-Time Student at any time, that child is no longer eligible even if that child becomes a Full-Time Student again at a later date.

"Creditable Coverage" means:

- A group health plan;
- Health insurance coverage (includes individual coverage);
- Part A or Part B Medicare;

- Medicaid;
- 10 U.S.C. ch. 55;
- A health or medical care program provided through the Indian health service or a tribal organization;
- A state health benefits risk pool;
- A health plan offered under 5 U.S.C. ch. 89; or
- A public health plan as defined under federal regulations.

3.4 Individuals not Eligible for Dependent Coverage

The following are not eligible for Coverage as a Dependent:

3.4.1 A Spouse or child, while on active duty in the armed forces of any country;

3.4.2 A Dependent child's legal dependent;

3.4.3 A child for whom you have only temporary custody or no legal obligation to support; or

3.4.4 A child already receiving Coverage as the Dependent of another Subscriber under this Agreement.

Notwithstanding the above, a common law spouse qualifies as a Spouse under the Agreement only if his/her spousal status is recognized in the state.

SECTION 4: ENROLLMENT

All eligible Employees of a Group and their eligible Dependents may enroll with the Health Plan for Coverage under the Agreement during the Group Enrollment Period. After the Group Enrollment Period, an eligible Employee or Dependent may enroll only if they qualify as a new or transfer Employee, under a valid waiver, or for a Special Enrollment Period as provided in section 4.4 below.

4.1 Group Enrollment Period

The Group Enrollment Period allows open enrollment for all eligible Employees and Dependents for a period of thirty-one (31) days.

4.2 New or Transfer Employees

An Employee who is new or transfers into the Health Plan Service Area after the Group Enrollment Period, may enroll by submitting a Health Plan Enrollment Application within thirty-one (31) days after becoming eligible. If the Employee fails to submit a Health Plan Enrollment Application for purposes of enrolling with the Health Plan for Coverage under the Agreement within thirty-one (31) days after becoming eligible, he/she is not eligible to enroll until the next Group Enrollment Period.

4.3 Valid Waiver

If the Employee waived Coverage under this Health Plan during the Group Enrollment Period because the Employee or Dependent(s) had other health insurance, the eligible Employee and his or her eligible Dependents may enroll within thirty-one (31) days of the loss of that coverage for any reason other than voluntary termination. Acceptable reasons include:

4.3.1 COBRA continuation coverage, which has since been exhausted; or

4.3.2 Health insurance coverage, that has since terminated as a result of:

4.3.2.1 Termination of employment;

4.3.2.2 Loss of eligibility due to a reduction of hours of employment;

4.3.2.3 Termination of the other health benefit plan;

4.3.2.4 Death of a Spouse;

4.3.2.5 Divorce; or

4.3.2.6 The Employee or Dependent no longer living or working in the other health insurance plan's HMO service area (where applicable).

If the eligible Employee or Dependent enrolls within the thirty-one (31) day period, Coverage under the Health Plan will become effective no later than the first (1st) day of the first (1st) calendar month after the date the completed request for enrollment is received, unless otherwise provided by the Group Master Contract.

The following statement is applicable to Groups of fifty-one (51) or more employees:

4.3.3 **I**f an eligible Employee and/or his or her eligible Dependents waived Coverage under this Health Plan at any time when Coverage under the Health Plan was previously offered to them, the Employee and/or his or her eligible Dependents may enroll within sixty (60) days of the occurrence of the following:

4.3.3.1 Termination of the Employee or Dependent's health insurance through Medicaid or CHIP as a result of a loss of eligibility; or

4.3.4.2 The Employee or Dependent has become eligible for a premium assistance subsidy under Medicaid or CHIP.

Coverage under the Health Plan will become effective no later than the first (1st) day of the first (1st) calendar month after the date the completed request for enrollment is received (unless otherwise provided by the Group Master Contract.)

4.4 Special Enrollment Period

The Special Enrollment Period begins on the date when an eligible Employee gains a Dependent as the result of one of the following events:

4.4.1 Marriage or divorce;

4.4.2 Birth, adoption, or placement of a child for adoption; or

4.4.3 Issuance of a Qualified Medical Child Support Order to the Subscriber or Subscriber's Spouse.

The Special Enrollment period allows eligible individuals to enroll, subject to the provisions below within thirty-one (31) days of one of these events taking place, or the date such Dependent Coverage is available, whichever is later. The following individuals are eligible to enroll under this provision:

4.4.4 Employees. An Employee who is eligible but has not yet enrolled may enroll upon marriage or upon the birth, adoption or placement for adoption of his or her child (even if the child does not enroll).

4.4.5 Spouse. A Spouse may enroll at the time of marriage to a Subscriber, or, if not enrolled at the time of marriage, the Spouse may enroll upon the birth, adoption or placement for adoption of his or her child (even if the new child does not enroll).

4.4.6 New Dependents of Covered Employee. A child who becomes a Dependent of a Subscriber as a result of marriage, birth, adoption, placement for adoption, or a Qualified Medical Child Support Order may enroll at that time. A Dependent through birth or placement for adoption will be covered from the date of birth or placement for adoption, provided the Enrollment Form and Premium are submitted within sixty (60) days of birth or placement for adoption. If the child becomes a Dependent as a result of a Qualified Medical Support order, the Subscriber must provide Us a copy of the court order when enrolling the child.

4.4.7 New Dependents of Non-participating Employee. A child who becomes a Dependent of a non-enrolled Employee as a result of marriage, birth, adoption or placement for adoption may enroll at that time but only if the non-enrolled Employee is eligible for enrollment and enrolls at the same time.

An eligible Employee who qualifies for Special Enrollment because of a new eligible Dependent may enroll, subject to the provisions below, within thirty-one (31) days of the event taking place, or the date such Dependent Coverage is available, whichever is later.

4.5 Notification of Change in Status

A Subscriber must notify the Health Plan, through the Group, of any changes in eligibility or enrollment status within thirty-one (31) days after the date of the event. This notification must be submitted on a written Change of Status form to Customer Service or the Health Plan. Events qualifying as a change in status include, but are not limited to, changes in address, employment, divorce, marriage, Dependent status, Medicare eligibility or Coverage by another payer. The Health Plan should be notified within a reasonable time of the death of any Member.

SECTION 5: EFFECTIVE DATES

5.1 Effective Dates

5.1.1 **Enrollees During Group Enrollment Period**: An Employee who is eligible for Coverage under the Agreement, and enrolls during a Group Enrollment Period, will be Covered under the Agreement as of the Member Effective Date or a date mutually agreed to by the Health Plan and the Group. Family members enrolled with the Employee during the Group Enrollment Period will have the same Effective Date as the Employee.

5.1.2 **Newly Hired Employees**: A newly hired Employee who is eligible for Coverage will be Covered under the Agreement as of the date that he/she first becomes eligible for Coverage so long as the Health Plan receives the Employee's completed Enrollment Form within thirty-one (31) days of the date that the Employee first became eligible for Coverage. Family members enrolled with the newly hired Employee will have the same Effective Date as the Employee.

5.1.3 **Newly Eligible Employees**: An Employee of the Group who transfers into the Service Area, and had been otherwise eligible for Coverage under the Agreement will be Covered as of the first (1st) day of the month following the date that he/she first transfers into the Service Area so long as the Health Plan receives the Employee's Enrollment Form within thirty-one (31) days of the date that the Employee first becomes eligible for Coverage. Family members enrolled with the newly eligible Employee will have the same Effective Date as the Employee.

5.1.4 **Special Enrollees**: An Employee and any Dependents who are eligible for and enroll during a Special Enrollment Period, as described in Section 4.4, will be Covered the first (1st) day of the first (1st) calendar month following submission of a completed Enrollment Form except as specified below:

5.1.4.1 Coverage of a Dependent child born to a Subscriber or Dependent Spouse is effective from the date of birth for the treatment of injury or sickness, including medically diagnosed congenital defects, birth abnormalities, premature birth and routine nursery care. Coverage for a child adopted by a Subscriber or Dependent Spouse will be effective from the earliest of the date of such adoption or placement for adoption.

5.1.4.2 Coverage of a Dependent eligible as a result of a Qualified Medical Child Support Order will become effective as of the date specified in the order. If no date is specified in the order, Coverage will be effective as of the date the order is issued by the court.

5.1.5 **Changes to Group Master Contract**: If a change to the terms of the Group Master Contract, including the Group selection of the Schedule of Benefits or provision of optional benefits through a Rider, are agreed upon by Coventry and the Group, Your benefits may change accordingly. Any changes to Your insurance will become effective on the date a new or revised Group Master Contract and necessary benefit documents including, but not limited to, the Schedule of Benefits or Riders are issued to the Group.

5.1.6 **Changes to Subscriber's Employee Class:** If the Group Master Contract defines more than one (1) class or category of Employee, a Subscriber's benefits may change if they become eligible under a different Employee class or category. Any such changes will become effective upon proper notification to the Health Plan and in accordance with the Group Master Contract.

5.1.7 **Inpatient on the Member Effective Date:** Coverage for an eligible Employee or eligible Dependent who is confined as an inpatient in a Hospital, nursing facility or hospice will begin on the Member Effective Date corresponding to their enrollment without regard to their inpatient status. However, if a Member is covered by a prior plan under an extension of benefits provision pursuant to state law, services or supplies that are Covered, or required to be Covered, under the extension of benefits will be Covered under this Agreement subject to the Agreement's Coordination of Benefits Section.

SECTION 6: USING YOUR BENEFITS

6.1 Membership Identification (ID) Card

Every Health Plan Member receives a membership ID card. Carry Your Health Plan ID card with You at all times, and present it whenever You receive health care services. Your ID card tells Providers who to bill for Your services. If You do not present Your ID card prior to receiving health care services, You may be billed. If Your Health Plan ID

card is missing, lost, or stolen, contact the Health Plan Customer Service Department at (800) 257-4692 to obtain a replacement or visit Our website at www.chciowa.com.

Possession and use of an ID card is not an entitlement to payment or reimbursement for all services received. Coverage is subject to verification of eligibility and all the terms, conditions, limitations and exclusions set out in the Agreement.

6.2 Your Primary Care Physician ("PCP")

The role of the PCP is important to the coordination of Your care, and You are encouraged to contact Your PCP when medical care is needed. You and Your PCP will work together to maintain Your health, and Your PCP will provide or coordinate most of Your health care needs. This may include preventive health services, obtaining Authorization of certain services, consultation with Specialists and other Providers, and Emergency Services. Some health services must be Prior Authorized by the Health Plan.

6.3 Selecting Your Primary Care Physician ("PCP")

Members may choose their PCP from the provider directory, a list of Participating family and general practitioners, internists, obstetricians/gynecologists and pediatricians. When selecting a PCP, You may wish to contact individual Provider offices for additional information including, but not limited to, specifics of a Physician's training and experience or office hours and policies. One PCP may be selected for the entire family, or each Dependent may select a different PCP.

6.4 Participating Providers, In-Network Coverage

Health services described in the Agreement will be Covered when such services are:

6.4.1 Medically Necessary;

6.4.2 Not otherwise excluded;

6.4.3 Prior Authorized as necessary at the telephone number listed on Your ID card; and

6.4.4 Provided by a Participating Provider.

A Member is entitled to benefits for health services from a Non-Participating Provider only in the case of an Emergency or if a particular Medically Necessary health service is not available from a Participating Provider. The directory of the Health Plan's Participating Providers can be found on Our website: www.chciowa.com, or a Customer Service representative can tell you if a Provider is Participating. However, please note that We reserve the right to make changes in Our Participating Provider network as appropriate or necessary. You are responsible for verifying your Provider's Participation status.

The directory of the Health Plan's Participating Providers can be found on Our website: www.chciowa.com, or a Customer Service representative can tell you if a Provider is Participating in Our network. However, please note that We reserve the right to make changes in Our Participating Provider network as appropriate or necessary. You are responsible for verifying Your Provider's Participation status.

When additional medical services are needed, ask if all services will be provided by the Participating Provider (including tests, x-rays, or diagnostic procedures) to ensure Coverage. If You are referred to a Specialist or hospitalization is required, BE SURE to verify that the Specialist and facility, if applicable, are Participating and the service is a Covered Service.

6.5 Out-of-Network Exception for Non-Emergency Services

If services are not available from a Participating Provider then You may obtain that care from a Non-Participating Provider **only if** You request and We approve an exception **prior to** receipt of care. Exceptions to Cover services of a Non-Participating Provider may be granted when the Health Plan determines that the Medically Necessary services cannot be received from a Participating Provider within the Network.

For consideration of an exception, You or Your Provider must call or submit a request and receive Health Plan approval prior to scheduling or receiving such care. Requests for exceptions must be submitted to the Health Plan in writing, with supporting medical information. The Health Plan's medical staff will review the information submitted to determine if an exception is necessary and will notify You of the Coverage decision. If an exception is not specifically granted by the Health Plan prior to Your receipt of the services, the Out-of-Network services will not be Covered.

Please note that exceptions are not required for Coverage of Out-of-Network Emergency Services. Please refer to Section 8.2 of this Evidence of Coverage.

6.6 Coverage for Your Out-of-Area Dependent Child: Passport Program

If Your Covered Dependent child resides outside Your Health Plan's designated Service Area to live with a parent or attend school, Your Covered Dependent child may be able to participate in Coventry's Passport Program. Under the Passport Program, Covered Dependent children living outside Iowa can receive the In-Network level of benefits for Covered Services outside the Service Area as long as services are obtained from Providers in the Coventry Health Care National Network. For information regarding how to enroll in the Passport Program, please contact Customer Service (800) 257-4692 or visit Our website at www.chciowa.com.

6.7 Member Responsibility

Member Responsibility refers to the amount of expense for Covered Services that You will share with the Health Plan. These include any Copayments, Deductibles, and Coinsurance amounts listed on Your Schedule of Benefits.

You are responsible for paying any Copayments listed in Your Schedule of Benefits to Participating Providers at the time of service. Additional cost sharing amounts, including, but not limited to, any Coinsurance and Deductible, will be calculated and applied based on the Allowable Amount for Covered Services. The Health Plan will pay Providers the Allowable Amount reduced by any Copayment, Coinsurance or Deductible, which You are responsible for paying.

If Your Provider is Participating and the Utilization Management Program was followed, then any amount above the Allowable Amount will not be billed to You. If Your Provider is Non-Participating or the Utilization Management Program was not followed, then services will not be Covered and Your Provider will bill these amounts to You at a later time.

6.8 Application of Benefits Based on Provider Billing

The way Your Provider bills will determine how Your Health Plan's benefits will be applied. Some examples include:

- In order for the Preventive Services benefit to apply, Your Provider must bill/code the services using preventive diagnosis and/or procedure codes.
- If You go to a Provider to access more than one type of service in the same visit, applicable visit limits for each type of treatment will apply. So, if You go to a Provider and receive both physical therapy and spinal manipulation services on the same day, the physical therapy services on that date will apply to any physical therapy visit limit and the spinal manipulation services will apply toward any manipulation visit limit.
- If Your Provider takes a lab sample or specimen and sends the sample/specimen to an outpatient facility for processing or interpretation, the outpatient facility may bill You separately for their services. The bill from the outpatient facility will be subject to the outpatient facility Deductible, Coinsurance or other cost-sharing listed on Your Schedule of Benefits.

6. 9 How to Contact the Health Plan

Throughout this Evidence of Coverage, You will find that We encourage You to contact Us for further information. Whenever You have a question or concern regarding Covered Services or any required procedure, please contact Us at the Customer Service telephone number on Your identification card or by calling (800) 257-4692. Members may also submit online inquiries through secure messaging by visiting Our website at www.chciowa.com.

Telephone numbers and addresses to request review of denied claims, register complaints, place requests for Prior Authorization, and submit claims are listed in the Schedule of Important Telephone Numbers and Addresses included in the Agreement.

SECTION 7: UTILIZATION MANAGEMENT

7.1 Utilization Management Program

Our Utilization Management Program is designed to assist You in receiving Medically Necessary health care in a timely and effective manner, at the appropriate level, in the appropriate setting, and at the most reasonable cost. The Utilization Management Program is an effective measure in helping to monitor the quality and cost-effectiveness of Your health care.

When You receive care from a Participating Provider, Your Provider is responsible for following the Utilization Management policies and procedures and **may** Prior Authorize services on Your behalf. If You use a Non-Participating

Provider, You are solely responsible for obtaining Prior Authorization from Us and will be responsible to ensure the Utilization Management policies for Prior Authorization are followed.

You are responsible for determining if Your Provider is Participating or Non-Participating. It is always Your responsibility to confirm and/or obtain any required Authorization either directly or through Your Provider before receiving health services.

7.2 Utilization Management Reviews

Not all medical services are Covered. Medical services must be Medically Necessary and be listed as a Covered Service under the Agreement to be covered. Utilization Management reviews are performed to determine Medical Necessity under the following circumstances:

7.2.1 **Prospective or Pre-Service Review**: Conducting utilization review for the purpose of Prior Authorization is commonly called prospective or pre-service review. A prospective review will determine whether the requested service or admission meets Medical Necessity criteria and is Covered *before* a non-Emergency service or Hospital admission.

7.2.2 **Concurrent Care Review**: This review occurs at the time care is being provided. When You are an inpatient in the Hospital, confined to a nursing facility, or receiving ongoing outpatient services, concurrent review will be conducted to determine ongoing Medical Necessity for such care.

7.2.3 **Retrospective or Post-Service Review**: Retrospective or post-service utilization review occurs for medical services that have not been Prior Authorized by the Health Plan, after services have been provided.

Following a Utilization Management review of all of the documentation provided, We will inform You and the requesting Provider, as appropriate, of Our determination. You have the right to Appeal any Utilization Management Program decision according to Our Complaint and Grievance Procedures, as set forth in Section 14.

7.3 Prior Authorization Requirements

Some services and supplies require Prior Authorization before receiving that service or supply. To determine which services and supplies require Prior Authorization, please contact Customer Service at the number on Your ID card. Because the services requiring Prior Authorization are subject to change, Customer Service can provide the most up to date information. In general, there are some Prior Authorization policies You should know:

7.3.1 You or Your Provider must request Prior Authorization from Us prior to all non-Emergency Hospital admissions or outpatient surgeries or other outpatient procedures.

7.3.2 We request You contact Us at least seven (7) business days prior to a scheduled Hospital admission or outpatient surgery or other outpatient procedures to ensure review in a timely manner.

7.3.3 Emergency screening and stabilization do not require Prior Authorization; however, notify Us as soon as is reasonably possible. Services following stabilization may require Prior Authorization, especially if Your Providers are Out-of-Network.

7.3.4 If You require organ or tissue transplant services, Your services and admission to a Coventry Approved Transplant Facility must be Prior Authorized.

7.3.5 If Your Agreement provides Coverage under a Mental Disorder and Substance-Related Disorder Rider, Prior Authorization must be obtained from the telephone number listed on Your ID card.

7.3.6 Failure to provide sufficient notice or to obtain Prior Authorization when required may result in reduction or denial of benefits.

7.4 Primary Care Physician (PCP) Authorizations

All care must be obtained from a Participating Provider unless specifically Authorized by the Heath Plan in accordance with Our policies and procedures. Coverage for certain health services, set forth in the Schedule of Benefits, obtained from Participating Providers require Prior Authorization through the Health Plan.

Your PCP or the Participating Provider who admits You to an inpatient or outpatient facility may obtain Prior Authorization from the Health Plan on Your behalf. Members are responsible for verifying that the requested health services are Covered under their Agreement, and confirming the required Prior Authorization has been granted before receiving the health services.

If Your PCP feels that You need to see a Physician or other medical Provider who is Non-Participating, then Your Physician must call or submit medical information to Us in writing. Our medical management staff will review the information and will notify Your Physician of the decision. PCPs do not have the authority to independently bind Us to Coverage for medical services that are not Covered Services as described in the Agreement or mandated by state law.

Questions regarding Coverage for services or Provider participation status should be directed to the Health Plan, not Your PCP. To verify Coverage of services or Provider participation status, please contact Customer Service.

7.5 Case Management

Case Management is a voluntary program intended to provide assistance to Members with certain serious, complicated, chronic or other conditions. If a Member participates in the Case Management Program, We will coordinate with the Member, their family members and Providers to develop a Medically Necessary care plan that is intended to:

7.5.1 Respond to the Members' health care needs; and

7.5.2 Be cost-effective and promote efficient use of their Coverage.

It is the Member's decision whether or not to participate in Our Case Management Program. Our Case Management Program does not replace the care received from the Member's Provider. The Member and his or her Physician remain in charge of the Member's health care treatment plan.

7.6 New Technology Assessment

The Health Plan uses a new technology assessment review process to evaluate the appropriate use and Coverage for new medical technologies or new applications of existing technologies, including, but not limited to medical procedures, drugs and drug therapies, and devices.

The process includes review of current published authoritative medical and scientific information pertaining to the proposed technology. Information will be obtained from such sources as, applicable medical and scientific journals, medical databases, specialty medical societies, applicable government publications, the Health Plan Medical Directors, Pharmacy Department, and specialists, researchers, or institutions who specialize in the condition involved as needed.

The following factors will be considered when evaluating the proposed technology:

7.6.1 The technology must have final approval from the appropriate regulatory bodies;

7.6.2 The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes; and

7.6.3 The technology must improve the net health outcome and must be as beneficial as any established alternatives.

To use a technique before it has been adequately tested and established may pose a risk to a patient's safety or require the use of substantial resources with no reasonable likelihood of benefit from treatment.

This process has been established to make Our determinations for Coverage based on a scientifically and medically sound process that will appropriately identify and distinguish those procedures, drugs and devices that have not yet been proven to be sufficiently safe and effective.

To prevent exposure to unwarranted risk and ensure the effective use of medical resources, the Health Plan excludes Coverage for new technology procedures, drugs and devices that are deemed by Us to be Experimental or Investigational.

SECTION 8: COVERED SERVICES

The Health Plan Covers only those health services, supplies, drugs, and equipment that are:

- Listed as a Covered Service below or in an attached Rider or Amendment;
- Deemed Medically Necessary by Us; and
- Not excluded under the Exclusions and Limitations set forth in the Agreement.

Only services and treatments that both meet Our Medical Necessity criteria and are listed as Covered Services in the Agreement will be Covered. Services and treatments listed under the Exclusions and Limitations Section are not Covered, regardless of Medical Necessity.

If You will be obtaining a service You believe to be Medically Necessary, but it is not specifically listed and not otherwise excluded, please contact Us so that We may confirm whether the service, supply, drug, or equipment is a Covered Service.

Some services require Prior Authorization. The services requiring Prior Authorization are subject to change. Your Provider may call on Your behalf, but it is ultimately Your responsibility to contact Customer Service to determine if Prior Authorization is necessary and to request Prior Authorization. In general, You should call Customer Service before scheduling:

- Outpatient surgical procedures;
- Non-Emergency hospitalizations;
- Home health care;
- Prosthetics and Durable Medical Equipment;
- Short-term therapy or rehabilitation;
- Transplants;
- Outpatient services not provided in a Physician's office;
- High Technology Diagnostics; and
- Out-of-Network services.

The following table of Covered Services is provided to assist You with determining the services and supplies that are Covered Services when determined to be Medically Necessary. This table does not provide the amount of Your cost-sharing responsibility. Please refer to Your Schedule of Benefits for any applicable Copayments, Deductibles, Coinsurance, or benefit limits.

8.1 Table of Covered Services

COVERED SERVICES OR SUPPLIES WHEN DETERMINED BY THE HEALTH PLAN TO BE MEDICALLY NECESSARY AND ANY NECESSARY PRIOR AUTHORIZATION HAS BEEN OBTAINED		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**EXCLUSIONS & LIMITATIONS***
*The Exclusions and Limitations listed in this table are not meant to be an exhaustive list. Please refer to the Exclusions and Limitations Section.		
Allergy	Covered Services for allergy testing, diagnosis, treatment, allergy serum, and the administration of injections.	**Exclusions:** • Installation of air filters, air purifiers, air ventilation system cleaning; or • Over-the-counter allergy medications, except as Covered in an Outpatient Prescription Drug Rider.
Ambulance	Covered Services for ground ambulance to the nearest facility when ambulance travel is determined to be Medically Necessary. Covered Services for air ambulance due to an Emergency Medical Condition.	**Exclusions:** Ambulance transportation due to the absence of other transportation on the part of the Member.
Blood and Blood Products Administration	Covered Services for administration, storage, and processing of blood and blood products in connection with Medically Necessary services.	**Exclusions:** • Services and associated expenses related to personal blood storage,

COVERED SERVICES OR SUPPLIES WHEN DETERMINED BY THE HEALTH PLAN TO BE MEDICALLY NECESSARY AND ANY NECESSARY PRIOR AUTHORIZATION HAS BEEN OBTAINED		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**EXCLUSIONS & LIMITATIONS***
*The Exclusions and Limitations listed in this table are not meant to be an exhaustive list. Please refer to the Exclusions and Limitations Section.		
		unless associated with a scheduled surgery; • Fetal cord blood harvesting and storage; or • Whole blood and blood products replacement to a blood bank.
Breast Reconstruction	Covered Services consistent with the Women's Health and Cancer Rights Act of 1998, if You have a mastectomy and elect reconstructive surgery in connection with the mastectomy, Coverage will be provided for: • Reconstruction of the breast on which the mastectomy was performed; • Surgery and reconstruction of the other breast to produce a symmetrical appearance; and • Breast prostheses and physical complications of mastectomy, including lymphedema. Covered Services for reconstructive breast surgery following a mastectomy regardless of the lapse of time since the mastectomy.	May require Prior Authorization. **Exclusions:** • Breast reduction or augmentation unrelated to a Medically Necessary mastectomy; or • Services and treatments not provided in the most cost-effective manner.
Cardiac Rehabilitation Therapy	Covered Services, but limited to treatment for therapy conditions that in the judgment of a Participating Physician and the Medical Director are subject to significant improvement of Your condition through short-term therapy, as determined by Us.	Requires Prior Authorization. **Limitations:** Limited to Your Group short-term therapy benefits as listed in Your Schedule of Benefits. **Exclusions:** Phase III therapy (unmonitored rehabilitation).
Chemotherapy and Radiation Therapy	Covered Services for standard chemotherapy and radiation therapy, not determined to be Experimental and Investigational.	May require Prior Authorization.
Chiropractic Services	Please refer to "Manipulative Therapy" benefit.	

COVERED SERVICES OR SUPPLIES WHEN DETERMINED BY THE HEALTH PLAN TO BE MEDICALLY NECESSARY AND ANY NECESSARY PRIOR AUTHORIZATION HAS BEEN OBTAINED		
SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**EXCLUSIONS & LIMITATIONS***
*The Exclusions and Limitations listed in this table are not meant to be an exhaustive list. Please refer to the Exclusions and Limitations Section.		
Clinical Trials	Covered Services for routine Patient Costs associated with a cancer clinical trial and for which a Covered Individual voluntarily participates. Please refer to Section 8.5.and the definition of Patient Costs in Section 1.	Requires Prior Authorization.
Cochlear Implant	Covered Services for the pre-implant evaluation, the implant system, surgery, and post-surgical fitting for cochlear implants.	May require Prior Authorization.
Colon Cancer Screening	Covered Services for screening for colorectal cancer for any nonsymptomatic person fifty (50) years of age and older. Such screening will include a maximum of: • One (1) screening fecal occult blood test annually; • A flexible sigmoidoscopy every five (5) years; • A colonoscopy every ten (10) years; and • A barium enema every five (5) to ten (10) years.	May require Prior Authorization.
Dental and Oral Services	Covered Services are limited to: • The removal of tumors and cysts of the jaws, lips, cheeks, tongue, roof and floor of the mouth, and removal of bony growths of the jaw, soft and hard palate; and • Device for dental protection during radiation for malignancy.	**Exclusions**: • Removal of dentigerous cysts, mandibular tori and odontoid cysts are excluded as they are dental in origin; • Removal of teeth prior to radiation or for radionecrosis; • Preventive dental and oral services; • X-rays or Physician exams involving one or more teeth, surrounding tissue or structure, alveolar process or gums; • Care, treatment, filling, removal, replacement, repair, or artificial restoration of the teeth (appliances, implants, crowns, dentures or other prosthetic devices); • Periodontal care; • Root canals;

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**EXCLUSIONS & LIMITATIONS***
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		• Surgery for impacted teeth; • Surgery involving structures directly supporting the teeth; • Orthodontia; • Treatment of gums; or • Dentures and related services.
Dental and Oral Services-Accident Only	Covered Services are limited to: • Emergency treatment of trauma, such as fracture of jaw or laceration of mouth, tongue or gums. • Dental services, supplies or appliances required as the direct result of an accidental injury where: o Dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident; o Treatment is initiated within 3 months of the accident, unless special accident-related medical circumstances exist that would prohibit treatment from starting in that timeframe; and o Treatment is concluded within 12 months of the accident.	**Exclusions:** • Repair of dental damage resulting from normal activities of daily living; or • Repair of dental damage resulting from extraordinary use of the teeth.
Dental and Oral Services-Anesthesia/Hospital	Covered Services for Medically Necessary dental-related anesthesia and Hospital or ambulatory facility charges for Dependent child, who: • Is under age five (5); or • Developmentally disabled.	May require Prior Authorization. **Exclusions:** Professional fees for oral surgeons and dental Providers associated with Covered dental-related anesthesia, Hospital or ambulatory facility services.
Dermatological Services	Covered Services for the treatment of psoriasis, cystic acne, and removal of a skin lesion that interferes with normal body functions or is suspected to be malignant.	May require Prior Authorization. **Exclusions:** Services, procedures or surgeries determined to be Cosmetic.

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**EXCLUSIONS & LIMITATIONS***
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Diabetes Treatment and Supplies	Covered Services for: • Test strips for glucose monitoring; • Urine testing strips; • Insulin; • Injection aids, lancet and lancet devices, or syringes; • Blood glucose monitors; • Outpatient self-management training and patient management; • Insulin pumps and all supplies for the pump; • Insulin infusion devices; • Oral agents for controlling blood sugars; • Glucose agents and glucagon kits; • Insulin measurement and administration aids for the visually impaired; • Patient management materials that provide essential diabetes self-management information; • Podiatric appliances for the prevention of complications associated with diabetes; and • Home visits.	May require Prior Authorization. Blood glucose monitors may be obtained from Our national vendor at a reduced price. **Limitations:** If not Covered in an Outpatient Prescription Drug Rider, Coverage for blood glucose meters, lancet and lancet devices, test strips, insulin injection aids, syringes, oral agents for controlling blood sugars, and glucose agents and glucagon kits will be provided under this Evidence of Coverage. Some diabetes supplies may be Covered under Your "Durable Medical Equipment" benefit and subject to any limitations in the Schedule of Benefits.
Dialysis	Covered Services for hemodialysis and peritoneal services provided by participating outpatient or inpatient facilities or at home. Home dialysis, equipment, supplies, and maintenance are a Covered Service.	May require Prior Authorization. **Limitations:** Some dialysis supplies may be Covered under Your "Durable Medical Equipment" benefit and subject to any limitations in the Schedule of Benefits.
Disposable Supplies	Covered Services only for: • Ostomy; • Disposable diabetic supplies; and/or • Supplies used in addition to or as part of a piece of Covered Durable Medical	

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	Equipment (DME), if the supplies are needed to ensure proper functionality of the Covered DME.	
Durable Medical Equipment (DME)	Covered Services when determined to be for the treatment of a Covered illness or injury, or to improve the functioning of a malformed body part, and when all of the following circumstances apply: • It can withstand repeated use; • It is primarily and customarily used to serve a medical purpose; • It is generally not useful to a person in the absence of illness or injury; • It is the most cost effective type of equipment; • It is appropriate for use in the home; and • It is not otherwise excluded under the Exclusions and Limitations Section. Covered Services including, but not limited to, the following: standard wheel chairs; continuous passive motion devices after surgery; rental of the equipment for the administration of oxygen; and mechanical equipment necessary for the treatment of chronic or acute respiratory failure (ventilators and respirators).	May require Prior Authorization. **Limitations:** Please refer to Your Schedule of Benefits. **Exclusions:** • Replacements and repairs of Durable Medical Equipment, unless deemed Medically Necessary by Us; or • DME and braces used to return to athletic competition or recreational sporting activities.
Elective Sterilization	Please refer to "Family Planning" benefit.	
Emergency Services	Covered Services for services described in the definitions of "Emergency Services" and "Emergency Medical Condition/Emergency" in Section 1. Covered Services include Emergency Services for psychiatric and Substance-Related Disorder Emergency care as described in Section 8.2.	

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SERVICE OR SUPPLY	**CRITERIA AND COVERAGE PROVIDED**	**EXCLUSIONS & LIMITATIONS***
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Eyeglasses and Corrective Lenses	Covered Services for: • The first pair of intraocular or surgically placed corrective lenses following cataract surgery or corneal transplant; or • Gas permeable contact lenses following a corneal transplant.	**Exclusions:** • Vision care and optometric services including eye examinations for refractive correction, except as specifically Covered in a Rider; • Radial keratotomy; • Eyeglass frames and lenses; • Laser eye surgery or similar surgery done to treat refractive error; or • Sunglasses.
Family Planning	Covered Services for: • Sterilization for both sexes, counseling, treatment and follow-up; and • Information on birth control, insertion and removal of intra-uterine devices, measurement for contraceptive diaphragms, and other outpatient services.	**Exclusions:** • Over-the-counter birth control methods or contraceptive devices; • Prescription and over-the-counter contraceptives, unless covered in an Outpatient Prescription Drug Rider included in the Agreement; • Reversal of elective sterilization; or • Surrogate parenting.
Genetic Counseling	Covered Services for genetic counseling and studies that are needed for diagnosis or treatment of genetic abnormalities.	May require Prior Authorization.
Growth Hormone	Covered Services for growth hormone therapy for Dependent children less than nineteen (19) years of age who have been diagnosed to have an actual growth hormone deficiency according to clinical guidelines used by the Health Plan.	May require Prior Authorization. **Limitations:** Medical Necessity and Experimental and Investigational reviews will apply. Please contact the Health Plan for additional information. **Exclusions:** Treatment of idiopathic short stature.
Health Education	Covered Services for education and nutritional counseling for the treatment of diabetes. Please refer to "Nutritional Counseling" benefit.	May require Prior Authorization. **Exclusions:** • Weight reduction supplies, services, equipment, drugs, therapy and

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		procedures; • Any costs of enrollment in a health, athletic club, personal training or fitness classes; or • Diet programs or services.
Home Health Care	Covered Services when all the following requirements are met: • The service is ordered by a Physician; • Services required are of a type which can only be performed by a licensed nurse, physical therapist, speech therapist, or occupational therapist; • The services are a substitute or alternative to hospitalization; • Part-time intermittent services are required; • A treatment plan has been established and periodically reviewed by the ordering Physician; • The services are Authorized for Coverage by Us; • The agency rendering services is Medicare certified and licensed by the State of location; and • The Member is home bound.	May require Prior Authorization. **Limitations:** A limit upon the number of visits or days may apply. Please refer to Your Schedule of Benefits. **Exclusions:** • Private duty nursing; • Custodial care; • Respite care; • Convalescent care; or • Services to help meet personal, family, or domestic needs; including, but not limited to, help walking, getting in and out of bed, bathing, dressing, shopping, eating and preparing meals, performing general household services or taking medications.
Hospice	Covered Services when You are terminally ill and all of these conditions are met: • You elect to receive care in or by a state licensed hospice Provider; • Your Provider certifies that You have a life expectancy of six (6) months or less; and • Services are Authorized for Coverage by Us.	May require Prior Authorization. **Exclusions:** • Private duty nursing; • Custodial care; • Domiciliary/residential care; • Educational services; • Respite care; or • Convalescent care.

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Immunizations	Covered Services for children's immunizations pursuant to the Health Plan's criteria, based upon approval by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, the American Academy of Family Physicians, and the Guide to Clinical Preventative Services. Covered Services for adult immunizations pursuant to the guidelines developed by the Centers for Disease Control and the U.S. Taskforce of Preventive Guidelines. Covered adult immunizations, include, but are not limited to: • HPV vaccine, applicable to Members under age twenty-six (26); • Flu shots; • Meningitis vaccine; or • Tetanus shot. Please refer to Our website for further information on Covered immunizations.	**Exclusions:** Immunizations for travel or employment.
Infertility	Covered Services only for the diagnosis of Infertility.	**Exclusions:** Treatment of Infertility, except as provided in an Infertility Rider.
Inpatient Hospital	Covered Services for: • Room and board; • General nursing care; • Use of equipment and supplies; • Use of operating room/recovery room/treatment room; • Semi-private room or private room; • Intensive care, coronary care unit and related Hospital services; • Anesthesia services and supplies; • Laboratory and radiology examinations; and • Medication used while inpatient confined.	Non-Emergency services may require Prior Authorization. **Limitations:** Consistent with Our utilization management policy, all acute care Hospital admissions and continued stays are reviewed for Medical Necessity before and during the inpatient stay. Coverage is dependent on the establishment of Medical Necessity for the care. If the Hospital stay or portion thereof is determined not to be Medically Necessary, You and Your Provider will be notified.

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Jaw Joint Disorder Treatment	Not a Covered Service, except as provided in a Jaw Joint Disorder Rider.	
Laboratory Services	Covered Services for laboratory tests, services, and materials.	**Limitations:** Laboratory services sent to or drawn at an outpatient facility are subject to the applicable outpatient facility Deductible, Coinsurance or other cost-sharing listed on Your Schedule of Benefits.
Mammograms	Covered Services for routine and diagnostic, low-dose screening mammograms, as follows: • One (1) baseline mammogram for a Covered woman age thirty-five through thirty-nine (35-39), or more frequently if directed by the woman's Physician; • One (1) mammogram every two (2) years for a Covered woman age forty through forty-nine (40-49), or more frequently if directed by the woman's Physician; and • One (1) mammogram every year for a Covered woman age fifty (50) or over, or more frequently if directed by the woman's Physician.	**Limitations:** Breast CT scans and MRIs may have additional requirements for Coverage and require Prior Authorization. Please contact the Health Plan for further information.
Manipulative Therapy	Covered Services for manipulation of the spine or other joints and muscles by any Provider, including chiropractors, and including an initial consultation, diagnosis and treatment.	**Limitations:** A visit and/or treatment limit may apply. Please refer to Your Schedule of Benefits. If You receive manipulative therapy and physical therapy during the same office visit, visit limits, as specified on Your Schedule of Benefits, will apply separately to manipulative therapy and physical therapy services. The therapy provided by a chiropractor must be within the scope of his or her professional license. **Exclusions:** Maintenance manipulative therapy, massage therapy, acupuncture, neuromuscular education, and acupressure.

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Maternity Services	Covered Services during the prenatal and postpartum period of pregnancy and during Hospital confinement. This will include complications of pregnancy of the mother and care for the newborn child as follows. • Inpatient care for a mother and her newborn child is Covered for a minimum of forty-eight (48) hours of inpatient care following a normal vaginal delivery and a minimum of ninety-six (96) hours of inpatient care following a cesarean section. • If, following a consultation between the mother and attending Physician, the mother and newborn are discharged prior to postpartum lengths of stay cited above. Coverage will be provided for up to two (2) home health care visits, provided that the first visit will occur within forty-eight (48) hours of discharge. • Cesarean sections (C-sections) will be covered in lieu of vaginal delivery when Medically Necessary, as determined by Us. • Additional services recommended by the American College of Obstetricians and Gynecologists (ACOG) for a woman of advanced maternal age (a woman age 35 or older at the time of delivery).	**Limitations:** Notification and Authorization required if You stay beyond forty-eight (48) hours following a normal vaginal delivery and in excess of ninety-six (96) hours following a cesarean section. **Exclusions:** • Abortions, except when the life of the mother would be endangered if the fetus were carried to term or if the fetus is diagnosed to have a congenital defect incompatible with life; • Breast pumps; or • Elective Cesarean section (C-section), including a cesarean section to accommodate the Member's or Provider's schedule, or other reason not related to Medical Necessity.
Medical Complications	Covered Services for: • Complications arising from Covered Services; or • Complications arising from services received prior to the Member Effective Date, if the services resulting in the complication are services that would have been Covered.	Non-Emergency services may require Prior Authorization. **Exclusions:** • Complications that occurred when You did not follow the course of treatment prescribed by a Provider; or • Complications that arise from non-Covered Services. Although the requested service may be Medically Necessary, if the complication is related to or as a result of a non-Covered Service, the requested service

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		will be denied for Coverage (including, but not limited to, any service, supply, equipment, drug or procedure that is required either directly or indirectly as a result of receiving a non-Covered Service). This exclusion includes complications that arise from any service covered under Your prior group health plan if that service is a non-Covered Service under this Agreement.
Mental Disorder, Substance-Related Disorder and Biologically Based Mental Illness Services	Not a Covered Service for non-Emergency Mental Disorder, Substance-Related Disorder and Biologically Based Mental Illness, except as provided in a separate Rider.	Please refer to Mental Disorder, Substance-Related Disorder and Biologically Based Mental Illness Services Rider, if applicable.
Newborn Care	Covered Services for treatment of diagnosed congenital defects, birth abnormalities, or prematurity, from the moment of birth. Delivery and related care for the newborn are Covered under the "Maternity Services" benefit, which provides for inpatient care for both the mother and newborn for the minimum of forty-eight (48) hours of inpatient care following a normal vaginal delivery and a minimum of ninety-six (96) hours of inpatient care following a Cesarean section, or longer with Prior Authorization.	Please refer to the Enrollment Section for further newborn Coverage requirements. **Limitations:** An Enrollment Form and Premium must be submitted to the Health Plan within sixty (60) days for the newborn to be eligible. Coordination of Benefits provisions will apply to newborn benefits even if the newborn is not enrolled after the automatic Coverage period. **Exclusions:** • Food supplements, including, but not limited to, infant formula, formula for enteral feedings, electrolyte supplements, or donor breast milk, unless provided in a Rider; • Treatment for developmental conditions; • Treatment for feeding and eating disorders of infancy and early childhood; or • Care provided to the newborn child of a Member covered as a Dependent child of the Subscriber.

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Nursing Facility/Nursing Care	Covered Services only when the services are a substitute or alternative to hospitalization. Coverage includes, but is not limited to, medical supplies, equipment, drugs and biologicals ordinarily furnished by the nursing facility, or Hospital if no designated nursing care beds are available within a 30-mile radius.	May require Prior Authorization. **Limitations:** Maximum benefits or limitations on the number of days may apply. Please refer to Your Schedule of Benefits. **Exclusions:** • Custodial and domiciliary care; • Residential care; • Educational services; • Rest cures; • Convalescent care; or • Respite care.
Nutritional Counseling	Covered Services for education and nutritional counseling for the treatment of diabetes. Please refer to "Health Education" benefit.	May require Prior Authorization. **Exclusions:** • Weight reduction supplies, services, equipment, drugs, therapy and procedures; • Any costs of enrollment in a health, athletic club, personal training or fitness classes; or • Diet programs or services.
Occupational Therapy	Covered Services when determined to be necessary to restore normal physical function for impairment due to trauma, stroke, a surgical procedure, or other acute condition, and significant improvement is reasonably anticipated.	**Limitations:** A visit limit may apply. Please refer to Your Schedule of Benefits. **Exclusions:** Treatment for autism, developmental delay, sensory integration disorder and/or maintenance therapy, unless otherwise required by state law.
Off-Label Prescription Drugs	Covered Services only for FDA approved drugs prescribed for an off-label use: • If the drug has been recognized to be safe and effective for off-label use based on clinical evidence reported in Peer-	**Limitations:** Please contact the Health Plan for further information.

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	Reviewed Medical Literature; or • As required by state law for specific life-threatening conditions.	
Orthotics	Covered Services for the treatment of diabetes if the orthotic device: • Is primarily and customarily used to serve a medical purpose; • Can withstand repeated use; and • Is Authorized for Coverage by Us.	May require Prior Authorization. **Limitations:** Only care and devices provided in the most cost effective manner available will be Covered. Please refer to the prosthetics section of Your Schedule of Benefits. **Exclusions:** Foot orthotics, except in the case of diabetes treatment.
Oxygen	Covered Service.	
Physical Therapy	Covered Services when determined to be necessary to restore normal physical function for impairment due to trauma, stroke, a surgical procedure, or other acute condition, and significant improvement is reasonably anticipated.	**Limitations:** A visit or treatment limit may apply. Please refer to the short-term therapy section of Your Schedule of Benefits. If You receive physical therapy and manipulative therapy during the same office visit, visit limits, as specified in Your Schedule of Benefits, will apply separately to physical therapy and manipulative therapy services. **Exclusions:** Treatment for autism, developmental delay, sensory integration disorder and/or maintenance therapy, unless otherwise required by state law.
Podiatry	Covered Services for treatment of the foot.	**Exclusions:** • Removal or reduction of corns and calluses; • Clipping of toenails; • Treatment of flat feet; • Fallen arches;

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		• Routine foot care for anything other than for the treatment of diabetes; or • Chronic foot strain.
Preventive Services	Covered Services for: • Routine physical examination, including laboratory tests and x-rays; • Well-child care, from birth to age eighteen (18) for certain well-child care services as defined by the U.S. Preventive Services Task Force and Advisory Committee on Immunization Practices. Such well-child care includes a history and complete physical examination as well as developmental assessment, anticipatory guidance, immunizations, vision and newborn hearing screening, and laboratory services including, but not limited to, screening for lead exposure as well as blood levels; • PSA test, one in a twelve (12) month period and digital rectal examinations, all in accordance with American Cancer Society Guidelines; • Colon cancer screening (Please refer to the "Colon Cancer Screening" benefit for details); • Well-woman care, including one pap smear in a twelve (12) month period; • Screening mammography (Please refer to the "Mammograms" benefit for details); or • Counseling for tobacco use and tobacco-caused disease. The Provider must bill/code services as preventive in order for the Preventive Services benefit to apply.	**Limitations:** Preventive care does not include any service or benefit intended to treat an existing illness, injury or condition. Please note that some Covered Services You receive during a preventive care office visit may not qualify as preventive care under this section. Please refer to Your Schedule of Benefits to determine if preventive services, described under the Covered Services Section of the Agreement, are exempt from any Deductible. **Exclusions:** Tobacco cessation treatment and prescription and over-the-counter products used to quit tobacco usage.
Professional Services	Covered Services for: • Diagnosis and treatment by a Physician or ancillary medical personnel and other	

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	services provided by licensed medical professionals; • Inpatient Hospital care, outpatient care and office visits; • Surgical procedures; or • Consultations with and treatment by Specialists.	
Prosthetic Devices	Covered Services for initial prosthetic device for the treatment of an illness or injury, or to improve the functioning of a malformed body part.	May require Prior Authorization. **Limitations:** Only care and devices provided in the most cost effective manner available will be Covered. A refitting and replacement is only Covered when determined to be Medically Necessary. **Exclusions:** Hearing aids.
Pulmonary Rehabilitation Therapy	Covered Services, limited to outpatient treatment for conditions that in the judgment of a Participating Provider and Our Medical Director are subject to significant improvement of Your condition.	May require Prior Authorization. **Limitations:** A visit limit may apply. Please refer to the short-term therapy section of Your Schedule of Benefits.
Radiology	Covered Services for diagnostic and therapeutic radiology services and High Technology Diagnostics, unless determined to be Experimental or Investigational.	High Technology Diagnostics may require Prior Authorization.
Reconstructive Surgery	Covered Service for: • Repair of disfigurement resulting from an injury which causes physical pain; • Reconstruction incidental to a Medically Necessary surgery; • Surgery that substantially improves functioning of any malformed body part; or • Correction of a congenital defect for Dependent children, unless specifically	May require Prior Authorization. **Exclusions:** • Panniculectomy resulting from weight loss; • Surgery determined to be Cosmetic; • Complications as a result of Cosmetic surgery; or • Scar revisions deemed to be Cosmetic.

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	excluded elsewhere in the Agreement. Breast reconstructive surgery is Covered for post mastectomy patients. (Please refer to the "Breast Reconstruction" benefit.)	
Sleep Studies	Covered Services when performed in an accredited facility.	May require Prior Authorization.
Speech Therapy	Covered Services for necessary treatment to restore speech loss or speech impairment due to trauma, stroke, a surgical procedure, child's hearing condition or other acute condition, and significant improvement is expected.	**Limitations:** A visit limit may apply. Please refer to the short-term therapy section of Your Schedule of Benefits. **Exclusions:** Speech therapy for autism, developmental delay, or sensory integration disorder in children, unless otherwise required by law.
Spinal Manipulation	Please refer to "Manipulative Therapy" benefit.	
Surgical Services	Covered Services, unless excluded under the Exclusions and Limitations section. For oral surgery services, please refer to the "Dental and Oral Services" benefits.	May require Prior Authorization. **Exclusions:** • Cosmetic surgery; or • Bariatric, lap band, gastric bypass or other weight loss surgery.
Temporomandibular Joint Syndrome ("TMJ")	Please refer to "Jaw Joint Disorder" benefit.	
Therapeutic Injections and IV Infusions	Covered Services for FDA-approved Therapeutic Injections and IV Infusions when administered in an inpatient setting, an outpatient facility, Provider's office, or home.	Services other than chemotherapy and certain Self-Administered Injectable medication may require Prior Authorization. **Limitations:** Certain Self-Administered Injectable medication may be Covered in an Outpatient Prescription Drug Rider and are excluded from the medical benefit. Therapeutic Injections are subject to the Health Plan's preferred list and

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		substitution by therapeutically interchangeable drugs, according to clinical guidelines used by the Health Plan.
Transplants	Please refer to Section 8.4.	Requires Prior Authorization. **Limitations:** **Transplants must be provided by a Coventry Approved Transplant Facility.**
Urgent Care	Covered Service.	

8.2 Emergency Benefits

In the event You experience an Emergency Medical Condition, contact Your Physician before receiving services if time permits. If You are unable to contact Your Physician, seek help immediately at the nearest Participating Hospital, Participating Physician's office or other Participating emergency facility. If You are unable to indicate a choice of Hospital, or if travel to the nearest Participating Hospital would create a danger to Your health, You should obtain medical attention from the nearest Hospital or through 911 Emergency Services (where available).

Screening and stabilization services provided in a Hospital emergency room for an Emergency Medical Condition received from either Participating or Non-Participating Providers will be Covered and do not require Prior Authorization. Services provided by Non-Participating Providers or in Non-Participating facilities will not be Covered if You remain in a Non-Participating facility after We have made the appropriate arrangements for transfer to a Participating facility.

8.2.1 What is an Emergency Medical Condition? An Emergency or Emergency Medical Condition means a medical or behavioral condition, the onset of which is sudden, manifesting itself by symptoms of sufficient severity, including, but not limited to, severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect that the absence of immediate medical attention, to result in:

8.2.1.1 Serious jeopardy to the health of the individual (or unborn child) or in the case of a behavioral condition, placing the health of the individual or others in serious jeopardy;

8.2.1.2 Serious impairment to bodily function;

8.2.1.3 Serious impairment to any bodily organ or part; or

8.2.1.4 Serious disfigurement.

An Emergency Medical Condition includes, but is not limited to, heart attacks, strokes, poisoning, seizures, severe bleeding and psychiatric emergency care.

8.2.2 What should You do if You experience an Emergency Medical Condition?

You should follow all the procedures listed below to ensure You will not be liable for the cost of the Emergency Services.

8.2.2.1 When an Emergency occurs, seek medical attention immediately. If you are admitted to the hospital, notify Us within twenty-four (24) hours or the next business day, circumstances permitting, or as soon as reasonably possible.

8.2.2.2 In the event You seek Emergency Services, and if deemed necessary in the opinion of the emergency health care Provider responsible for Your Emergency care and treatment and warranted by his or her evaluation; the emergency health care Provider may initiate necessary intervention to stabilize Your condition without seeking or receiving prospective Authorization from the Health Plan.

8.3 Mental Disorder, Substance-Related Disorder, and Biologically Based Mental Illness Services

The Health Plan Covers Mental Disorder, Substance-Related Disorder, and Biologically Based Mental Illness services to the extent listed on any Mental Disorder and Substance-Related Disorder Rider attached to this Evidence of Coverage. The Health Plan may contract with an outside vendor to coordinate, determine Medical Necessity of, administer Appeals and Grievances, and Prior Authorize the treatment of all Mental Disorders, Substance-Related Disorders and Biologically Based Mental Illness. Any contracted vendor and its telephone number will be listed on Your ID card and in the provider directory.

8.4 Transplant Services

Services related to Medically Necessary organ and tissue transplants are Covered when approved by Us and provided by a Coventry Approved Transplant Facility. **All transplant related services, including evaluation, require Prior Authorization.**

Donor screening tests are Covered as provided in Your Schedule of Benefits. If not covered by any other source, the cost of any care, including complications, arising from an organ donation by a non-Covered individual, when the recipient is a Member, will be Covered for the duration of the contract of the Member when approved by Us. The cost of any care, including complications, arising from an organ donation by a Member, when the recipient is not a Member, is excluded.

8.5 Clinical Trials

A cancer clinical trial is a course of treatment in which all of the following apply:

8.5.1 The treatment is part of a scientific study of a new therapy or intervention that is being conducted at an institution in that is for the treatment, palliation or prevention of cancer in humans and in which the scientific study includes all of the following:

8.5.1.1 Specific goals;

8.5.1.2 A rationale and background for the study;

8.5.1.3 Criteria for patient selection;

8.5.1.4 Specific directions for administering the therapy and monitoring patients;

8.5.1.5 A definition of quantitative measures for determining treatment response; and

8.5.1.6 Methods for documenting and treating adverse reactions.

8.5.2 The treatment is being provided as part of a study being conducted in a phase I, phase II, phase III or phase IV cancer clinical trial.

8.5.3 The treatment is being provided as part of a study being conducted in accordance with a clinical trial approved by at least one of the following:

8.5.3.1 One of the national institutes of health;

8.5.3.2 A national institutes of health cooperative group or center;

8.5.3.3 The United States food and drug administration in the form of an investigational new drug application;

8.5.3.4 The United States department of defense;

8.5.3.5 The United States department of veterans' affairs;

8.5.3.6 A qualified research entity that meets the criteria established by the national institutes of health for grant eligibility; or

8.5.3.7 A panel of qualified recognized experts in clinical research within academic health

institutions in this state.

8.5.4 The proposed treatment or study has been reviewed and approved by an institutional review board of an institution in this state.

8.5.5 The personnel providing the treatment or conducting the study:

8.5.5.1 Are providing the treatment or conducting the study within their scope of practice, experience and training and are capable of providing the treatment because of their experience, training and volume of patients treated to maintain expertise; and

8.5.5.2 Agree to accept reimbursement as payment in full from the accountable health plan at the rates that are established by the plan and that are not more than the level of reimbursement applicable to other similar services provided by health care providers with the plan's provider network.

8.5.6 There is no clearly superior, noninvestigational treatment alternative.

8.5.7 The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as efficacious as any noninvestigational alternative.

SECTION 9: EXCLUSIONS AND LIMITATIONS

9.1 GENERALLY EXCLUDED SERVICES/ITEMS

Generally excluded services/items include any service, supply, equipment, drug or procedure:

9.1.1 Determined by Us as not Medically Necessary;

9.1.2 Determined by Us as Experimental and Investigational;

9.1.3 For the treatment of an occupational injury or illness that is paid under Worker's Compensation laws;

9.1.4 For which payment is, by law, covered by any governmental agency, as a primary plan; that is not considered as a payer of last resort;

9.1.5 For which You have no financial liability or that was provided at no charge;

9.1.6 Furnished under or as part of a study, grant, research program or clinical trial, except as specified in the Covered Services Section;

9.1.7 Not listed as a Covered Service;

9.1.8 Not provided in the scope, licensure or certificate of the Provider;

9.1.9 Not provided or arranged in accordance with Our Utilization Management Program;

9.1.10 Paid by or recovered from a third party or insurance carrier after You have been fully compensated;

9.1.11 Provided after the date a Member's Coverage under the Agreement terminates, including services provided after the date of termination for medical conditions arising prior to the date a Member's Coverage terminates;

9.1.12 Provided as a result of a court-order or that are a condition of probation or parole;

9.1.13 Provided by a licensed Provider of health care which are not medical services or which may be performed by non-medical personnel;

9.1.14 Provided to a Member by a Provider with the same legal residence as the Member and/or a person who is part of the Member's immediate family, including spouse, brother, sister, parent, step-parent, child or step-child;

9.1.15 Related, directly or indirectly, as a result of receiving a non-Covered Service. This exclusion includes complications that arise from any service covered under Your prior group health plan if that service is a non-Covered Service under this Agreement;

9.1.16 Required while a Member is incarcerated, or in the custody of law enforcement;

9.1.17 Resulting, directly or indirectly, from You not following the course of treatment prescribed by a

Provider; or

9.1.18 The Member receives or is entitled to under Medicare Part A and eligible for under Medicare Part B (whether or not the Member has applied for or is enrolled in Medicare Part B).

9.2 SPECIFICALLY EXCLUDED SERVICES/ITEMS

Specifically excluded services/items include:

9.2.1 Abortions, except when the life of the mother would be endangered if the fetus were carried to term or if the fetus is diagnosed to have a congenital defect incompatible with life;

9.2.2 Acupuncture, acupressure or neuromuscular education;

9.2.3 Administrative or overhead fees, clinic charges, or charges associated with ownership and/or operation of a facility or any Provider/practice;

9.2.4 Allergies - Over-the-counter medications or non-Physician allergy services or associated expenses relating to an allergic condition including, but not limited to, installation of air filters, air purifiers, or air ventilation system cleaning;

9.2.5 Alopecia treatment, including the treatment of age-related hair loss;

9.2.6 Alternative therapies, including, but not limited to, aroma therapy, light therapy or massage;

9.2.7 Ambulance services for non-Emergencies or due to the absence of other transportation on the part of the Member;

9.2.8 Audiometric testing performed specifically for evaluation to determine treatment of hearing loss or for the use of hearing aids;

9.2.9 Autism or pervasive developmental conditions, developmental delays or sensory integration disorders (i.e., the brain's inability to integrate, process, and respond to certain information received from the body's sensory systems with respect to detecting sights, sounds, smell, tastes, temperatures, pain and the position and movements of the body), unless otherwise required by state law;

9.2.10 Batteries (external) for devices, including, but not limited to, wheelchairs, hearing aids, etc. Batteries are only Covered if they require operative placement, during or following a Covered surgery;

9.2.11 Behavior modification;

9.2.12 Behavioral conditions - Conditions described in the most recent Diagnostic and Statistical Manual of Mental Disorders as “V” codes, which are used when some circumstance or problem that influences the Member’s health status is present, but is not, by itself, a current illness or injury. Such conditions include, but are not limited to, relational problems, anti-social behavior, academic problems and phase-of-life problems;

9.2.13 Biofeedback;

9.1.14 Biologically Based Mental Illness, unless provided in a Rider;

9.2.15 Blood storage - Services and associated expenses related to personal blood storage, unless associated with a scheduled surgery; fetal cord blood harvesting or whole blood and blood products replacement to a blood bank;

9.2.16 Boot camps;

9.2.17 Braces and supports needed for athletic participation or employment;

9.2.18 Breast pumps;

9.2.19 Cardiac phase III therapy (unmonitored rehabilitation);

9.2.20 Cesarean section, if elective;

9.2.21 Cognitive rehabilitation;

9.2.22 Cosmetic services and surgery and the complications incurred as a result of those services and surgeries, including, but not limited to, breast augmentation or reduction not associated with cancer of the breast;

removal of skin lesions, unless the lesions interfere with normal body functions or malignancy is suspected; salabrasion; laser surgery; labioplasty; blepharoplasty; or chemosurgery;

9.2.23 Cranial orthosis, Dynamic Orthotic Cranioplasty (DOC) bands, molding helmet therapy, or surgical treatment of deformational plagiocephaly - See also: "Orthotic appliances and devices", Section 9.2.67;

9.2.24 Custodial and domiciliary care, residential care, or protective and supportive care including, but not limited to, educational services, rest cures, convalescent care, respite care, or any health-related services that do not seek to cure and are provided during periods when the medical condition of the patient is not changing or that do not require continued administration by trained medical personnel;

9.2.25 Day care;

9.2.26 Dementia treatment, the treatment of delirium, amnesia or cognitive disorders;

9.2.27 Dental care or treatment, including, but not limited to, X-rays, fillings, root canals, removal, replacement, repair, or artificial restoration of the teeth (e.g., appliances, implants, crowns, bridges, dentures, or other prosthetic devices); dental restorative care; periodontal care; surgery for impacted teeth; any Physician services or X-ray examinations involving one or more teeth, the tissue or structure around them, the alveolar process or the gums; surgery involving structures directly supporting the teeth; removal of dentigerous cysts, mandibular tori and odontoid cysts; removal of teeth due to an injury prior to radiation or radionecrosis, or preventive dental and oral services not required to immediately stabilize the mouth after an accident, unless otherwise required by state law;

9.2.28 Diet programs and supplies - See also: “Weight reduction”, Section 9.2.93;

9.2.29 Disposable take home items or consumable outpatient supplies, including, but not limited to, sheaths, bags, tubing, elastic garments and bandages, syringes, needles, blood or urine testing supplies, home testing kits, vitamins, dietary supplements and replacements, food, food supplements, and food replacements, and special food items, unless they are specified as Covered;

9.2.30 Driving tests or exams;

9.2.31 Durable Medical Equipment (DME) that is not Medically Necessary; including, but not limited to, bed boards, patient lifts; including, but not limited to, chair lifts, seat lifts, car lifts, shower lifts, toilet lifts and bed lifts, chairs and rails, over-bed tables, wheelchair trays, flotation devices, stethoscopes, blood pressure gauges, orthotics, DME and braces used to return to athletic competition or recreational sporting activities; and replacement and repair of DME, unless deemed Medically Necessary by Us;

9.2.32 Educational testing or psychological testing, including, but not limited to, evaluation or treatment of learning disabilities, minimal brain dysfunction, cerebral palsy, mental retardation, developmental and learning disorders and behavioral training, unless part of a treatment program for Covered Services;

9.2.33 Enteral feeding food supplements - The cost of formula used in outpatient enteral tube feedings;

9.2.34 Exams for employment, school, camp, sports, licensing, insurance, adoption, marriage, or functional capacity;

9.2.35 Exercise equipment, rental or purchase;

9.2.36 Eyeglass frames and lenses, contact lenses and sunglasses, except for the initial placement of lenses immediately after cataract or corneal transplant surgery;

9.2.37 Eye surgery or services, including, but not limited to, radial keratotomy, laser eye surgery or similar surgery done to treat refractive error, and eye exercises;

9.2.38 Feeding and eating disorders in infancy and early childhood, unless otherwise required by state law;

9.2.39 Food or food supplements, including, but not limited to, infant formulas, electrolyte supplements, or donor breast milk;

9.2.40 Foot care (routine), including, but not limited to, removal or reduction of corns and calluses, clipping of the nails, treatment of flat feet, fallen arches, foot orthotics, chronic foot strain, orthopedic shoes, shoe inserts and arch supports, heel lifts, cups and pads, except for the Medically Necessary treatment of diabetes;

9.2.41 Gastric bypass surgeries (both laparoscopic and open), including, but not limited to: Roux en-Y procedures, jejunoileal bypass, gastric banding, lap banding, biliopancreatic bypass, gastroplasty, and gastric balloon;

9.2.42 Hair analysis including, but not limited to, evaluation or treatment of alopecia or age-related hair loss;

9.2.43 Hair prostheses, wigs and transplants;

9.2.44 Health and athletic club membership - Any costs of enrollment in a health, athletic club, personal training or fitness classes;

9.2.45 Hearing aids or devices, including bone anchored hearing aids (BAHA), including the cost and fitting;

9.2.46 Home services to help meet personal, family, or domestic needs; including, but not limited to, help walking, getting in and out of bed, bathing, dressing, shopping, eating and preparing meals, performing general household services or taking medications;

9.2.47 Humidifiers, de-humidifiers, air-conditioners, space heaters, or any other equipment or service used to alter air quality or temperature;

9.2.48 Hypnotherapy;

9.2.49 Illegal Acts - Charges for services received as a result of injury or sickness occurring, directly or indirectly, as a result of Your commission of any illegal act (including, but not limited to, robbery, burglary, assault, acts of terrorism, or while driving on a suspended or revoked driver's license), regardless of whether a charge has been filed or guilt has been determined. This exclusion does not apply if the injury or sickness resulted from a medical condition or Mental Disorder or if You were a victim of an act of domestic violence;

9.2.50 Immunizations for travel or employment;

9.2.51 Infertility services, supplies, equipment, procedures and drugs relating to: artificial insemination with donor semen, the conception and pregnancy of surrogate mothers, surrogate childbirth, egg or sperm donation, cryopreservation, in vitro fertilization, and storage of sperm, eggs and embryos, or sterilization reversal, unless otherwise Covered by a Rider;

9.2.52 Learning disabilities treatment;

9.2.53 Long-term care and all services provided by such facilities;

9.2.54 Maintenance treatment or therapy that is not part of an active treatment plan intended to, or reasonably expected to, improve the Member's sickness, injury, or functional ability;

9.2.55 Marriage or relationship counseling and family counseling; or bereavement counseling;

9.2.56 Massage therapy;

9.2.57 Mental Disorders, except as provided in a Rider;

9.2.58 Mental retardation and disorders relating to learning; motor skills, or communication;

9.2.59 Motorized scooters or motorized vehicle customization;

9.2.60 Naturopathy;

9.2.61 Newborn care of a newborn child of a Member Covered as a Dependent child of the Subscriber (Subscriber's grandchild);

9.2.62 Non-emergent procedures, services, items or medications received or performed in a foreign country;

9.2.63 Non-prescription drugs and medications - Over-the-counter drugs and medications incidental to outpatient care and Urgent Care Services, unless Covered in an optional Outpatient Prescription Drug Rider;

9.2.64 No-show or non-cancellation charges incurred as a result of Your failure to appropriately cancel a scheduled appointment;

9.2.65 Oral surgery required as part of an orthodontic treatment program, required for correction of an occlusal defect, encompassing orthognathic or prognathic surgical procedures, involving removal of

symptomatic bony impacted third molars;

9.2.66 Orthodontia and related services;

9.2.67 Orthotic appliances and devices, including, but not limited to, cranial molding helmets, banding, and anything that changes the shape of the head (and repair and replacement), orthopedic shoes and other supportive devices for the feet, splints and braces (unless they are used instead of casts), orthotic appliances or devices specifically intended for sports or occupational purposes; or repair or replacement required because the device is lost, misplaced, misused or stolen. We do not Cover the replacement, repair or maintenance of any prosthetic item or device that is not Covered;

9.2.68 Over-the-counter (OTC) supplies that do not require a prescription to be dispensed, including, but not limited to, Ace wraps, elastic supports, finger splints, orthotics, braces, antacids, birth control methods or contraceptive devices, cervical collars and pillows, herbal products, medicated soaps, food supplements, and bandages;

9.2.69 Panniculectomy, resulting from weight loss;

9.2.70 Personal comfort and convenience items including, but not limited to, television, telephone, tissue, razor, toothbrush, toothpaste, barber or beauty services;

9.2.71 Pervasive developmental conditions, including, but not limited to, autism, unless otherwise required by state law;

9.2.72 Prescription drugs and medications that require a prescription and are dispensed at a Pharmacy for outpatient treatment, except as specifically Covered in the Covered Services Section of this Evidence of Coverage or as specifically provided in an optional Outpatient Prescription Drug Rider;

9.2.73 Private duty nursing;

9.2.74 Private inpatient room, unless Medically Necessary or if a semi-private room is unavailable;

9.2.75 Prosthetic devices and items except as Covered in the Covered Services Section of this Evidence of Coverage, including, but not limited to cosmetic prostheses (except for breast prostheses prescribed following a mastectomy for breast cancer or breast disease); mechanical organ replacement devices (including, but not limited to, mechanical hearts or left ventricular assist devices); repair or replacement required because the device is lost, misplaced, misused or stolen; or prosthetic mechanical devices or items specifically intended for sports or occupational purposes. We do not Cover the replacement, repair or maintenance of any prosthetic device or item that is not Covered;

9.2.76 Psychiatric evaluation or therapy when related to judicial or administrative proceedings or orders, when employer requested, or when required for school;

9.2.77 Scar or tattoo removal or revision procedures;

9.2.78 Sexual dysfunction aids and treatment including, but not limited to, penile prostheses, penile vacuum, and sex counseling or therapy**,** unless the aid or treatment is Covered in an Outpatient Prescription Drug Rider;

9.2.79 Sex transformation services, regardless of any diagnosis of gender role disorientation or psychosexual orientation, including, but not limited to, any treatment or studies related to sex transformation, and hormonal support for sex transformation;

9.2.80 Smoking or tobacco cessation drugs or treatment;

9.2.81 Substance-Related Disorders, except as provided in a Rider;

9.2.82 Surgery performed solely to address psychological or emotional factors;

9.2.83 Telephone consultations, internet or e-mail consultations, between Providers;

9.2.84 Temporomandibular Joint Disorder ("TMJ"), except as provided in a Rider;

9.2.85 Transplant services, and any related conditions or complications, for a Member who is donating an organ or tissue when the recipient is not a Member;

9.2.86 Transplant services and associated expenses involving temporary or permanent mechanical or animal

organs;

9.2.87 Travel or transportation expenses, even though prescribed by a Provider, other than Medically Necessary transportation Authorized for Coverage by Us or as specified in the Covered Services Section;

9.2.88 Treatment of idiopathic short stature;

9.2.89 Vax-D therapy;

9.2.90 Vision care and optometric services, including eye examinations for refractive correction not provided for in a Supplemental Benefit Rider, eye exercises and therapy; fitting or cost of visual aids, and eye glasses and corrective lenses, except as necessary for the initial placement of corrective or contact lenses following cataract surgery or corneal transplant performed while a Member of the Plan;

9.2.91 Vocational therapy or vocational or employment counseling;

9.2.92 War-related sickness, injury, and services or care for military services-connected disabilities and conditions for which You are legally entitled to Veteran Administration services and for which facilities are reasonably accessible to You;

9.2.93 Weight reduction supplies, services, equipment, drugs, therapy and procedures, including, but not limited to, diet programs, tests, examinations or services and medical or surgical treatments, including, but not limited to, intestinal bypass surgery, stomach stapling, balloon dilation, lap band, wiring of the jaw and other procedures of a similar nature; and

9.2.94 Work hardening programs.

SECTION 10: CLAIMS AND REIMBURSEMENT

10.1 Notice of Claims

If You presented Your identification card to a Participating Provider, You are not required to notify Us of proof of loss. If You are billed directly by a Provider, You should contact Customer Service at (800) 257-4692 to obtain the appropriate forms. We will provide You with the forms for filing proof of loss within fifteen (15) days from the date of Your request. You may also visit Our Member services page on the internet at: www.chciowa.com. If You do not receive these forms, We will accept Your written description of the loss as proof of loss.

10.2 Proof of Loss

Itemized statements of medical service must be furnished to Us within ninety (90) days after the date of such service. Failure to furnish such statements within ninety (90) days will not invalidate or reduce any claim if it were not reasonably possible to provide the statements within ninety (90) days. Except in the absence of legal capacity, bills will not be accepted later than one (1) year after the date of service.

10.3 Claims Payment

When Covered Services are provided by a Participating Provider, any benefits due will be paid to the Provider.

If Covered Services are provided by a Non-Participating Provider and approved by Us, benefits will be paid directly to the Non-Participating Provider unless payment has been made by You and is indicated as such on the claim form, invoice or statement submitted.

We reserve the right to allocate any financial penalty, Deductible, Copayment and balance remaining after Coinsurance to any individual or assignee.

10.4 Physical Examination

In the event of a question or dispute concerning Coverage, We may reasonably require that a Member be examined at Our expense by a Participating Provider acceptable to Us.

SECTION 11: COORDINATION WITH OTHER COVERAGE (COORDINATION OF BENEFITS-COB)

11.1 Coordination With Other Plans

This coordination of benefits ("COB") provision applies when a Member has health care coverage under more than one Plan. "Plan" is defined below.

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed one hundred percent (100%) of its total Allowable Expense.

11.2 Definitions of Terms Used in this Section

11.2.1 "A **Plan**" is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

a) "**Plan**" includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, including, but not limited to, skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

b) "**Plan**" does not include: hospital indemnity coverage or other fixed indemnity coverage; accident-only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under "a" or "b" is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

11.2.2 In a COB provision, "We/Us/Our" means the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from Our Health Plan. A contract may apply one COB provision to certain benefits, such as, dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

11.2.3 The order of benefit determination rules determine whether We are a "**Primary**" Plan or "**Secondary**" Plan when You have health care coverage under more than one Plan.

When We are Primary, Our benefits are determined before those of any other Plan and without considering any other Plan's benefits. When We are Secondary, Our benefits are determined after those of another Plan and may be reduced so that all Plan benefits do not exceed one hundred percent (100%) of Our Allowable Amount.

11.2.4 "**Allowable Expense**" means a health care service or expense including any Deductibles, Coinsurance and Copayments, that are covered, at least in part by any Plan covering You**.** When a Plan provides benefits in the form of service, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering You or Your Covered Dependent is not an Allowable Expense. In addition, an expense that a Provider, by law or in accordance with a contractual agreement, is prohibited from charging a Member, is not an Allowable Expense.

The following are examples of expenses or services that are **not** Allowable Expenses:

a) The difference between the cost of a semi-private room in the Hospital and a private room is not an Allowable Expense, unless one of the Plans provides benefits for private Hospital room expenses.

b) When a Member is covered by two (2) or more Plans that provide benefits or services on the basis

of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

c) When a Member is covered by two (2) or more Plans that calculate benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

d) When a Member is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowable Expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement, and, if the Provider's contract permits, the negotiated fee or payment will be the Allowable Expense used by the Secondary Plan to determine its benefits.

e) The amount of any benefit reduction by the Primary Plan because a Member does not comply with the Plan provisions is not an Allowable Expense. Examples of these provisions are second surgical opinions, pre-certification of admissions, and preferred Provider arrangements.

11.2.5 "**Closed Panel Plan**" is a Plan that provides health benefits to covered persons primarily in the form of services through a panel of Providers that have contracted with or are employed by the Plan, and that limits or excludes benefits for services provided by other Providers, except in cases of Emergency or referral by a panel member.

11.2.6 "**Custodial Parent**" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

11.3 Order of Benefit Determination Rules

When a Member is covered by two (2) or more Plans, the rules for determining the order of benefit payment are as follows:

11.3.1 The Primary Plan pays or provides its benefits according to its terms of coverage without regard to the benefits of any other Plan.

11.3.2 Except for supplemental coverage, as described in the following paragraph, a Plan that does not contain a coordination of benefits provision that is consistent with this provision is always Primary, unless the provisions of both Plans state that the complying Plan is Primary.

Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage will be excess to any other parts of the Plan provided by the contractholder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide Out-of-Network benefits.

11.3.3 A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is Secondary to that other Plan.

11.3.4 Each Plan determines its order of benefits using the first of the following rules that applies:

a) Non-Dependent or Dependent. The Plan that covers the Member other than as a dependent, for example as an employee, member, subscriber, or retiree, is Primary and the Plan that covers the Member as a dependent is Secondary. However, if the Member is a Medicare beneficiary and, as a result of federal law, Medicare is Secondary to the Plan covering the Member as a dependent, and Primary to the Plan covering the Member as other than a dependent (e.g., a retired Employee), then the order of benefits between the two (2) Plans is reversed so that the Plan covering the Member as an employee, member, subscriber or retiree is Secondary and the other Plan is Primary.

b) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one (1) Plan, order is determined as follows:

i. For a dependent child whose parents are married or are living together, whether or not they have ever been married:

- The Primary Plan is the Plan of the parent whose birthday falls earlier in the year; or
- If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.

ii. For a dependent child whose parents are divorced, separated, or not living together, whether or not they have ever been married:

- If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to benefit years after the Plan is given notice of the court decree;
- If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph (i) above will determine the order of benefits;
- If a court decree states that the parents have joint custody, without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provision of subparagraph (i) above will determine the order of benefits; or
- If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, and assuming dependent child coverage is available, the order of benefits for the child are as follows:
  - The Plan covering the custodial parent;
  - The Plan covering the spouse of the custodial parent;
  - The Plan covering the non-custodial parent; and then
  - The Plan covering the spouse of the non-custodial parent.

iii. For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of subparagraph (i) or (ii) above will determine the order of benefits as if those individuals were the parents of the child.

c) Active Employee, Retiree, or Laid-off Employee. The Plan that covers a Member as an active employee who is neither laid off nor retired, is Primary. The Plan covering that same person as a retired or laid-off employee is the Secondary Plan. The same would hold true if a Member is the dependent of an active employee and that same Member is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored.

d) COBRA or State Continuation Coverage. If a Member whose coverage is provided pursuant to COBRA, or under a right of continuation provided by federal or state law, is covered under another Plan, the Plan covering the Member as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

e) Longer or Shorter Length of Coverage. The Plan that covered the Member as an Employee, Member, Subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

If the preceding rules do not determine the order of benefits, the Allowable Expenses will be shared equally between the Plans meeting the definition of Plan under this regulation. In addition, this Plan will not pay more than We would have paid had We been Primary.

11.4 Effect On The Benefits of this Health Plan

11.4.1 When We are the Secondary Plan, We may reduce Our benefits so that the total benefits paid or provided by all Plans are not more than the total Allowable Expenses owed by Us. In determining the amount to be paid for any claim, when We are the Secondary Plan, We will calculate the benefits We would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under Our Plan that is unpaid by the Primary Plan. We may then reduce Our payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed Our total Allowable Expense for that claim. In addition, the Secondary Plan will credit to its Plan any amounts it would have credited to its Deductible or other Member Cost Share in the absence of other health care coverage.

11.4.2 If a Member is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed Panel Plan, COB will not apply between that Plan and other Closed Panel Plans.

11.5 Coordination of Benefits with Medicare

11.5.1 Active Employees and Spouses Age 65 and Older

If an Employee is eligible for Medicare and works for a Group with fewer than 20 Employees for each working day in each of twenty (20) or more calendar weeks in the current or preceding Benefit Year, then Medicare will be the Primary payer. Medicare will pay its benefits first. This Health Plan will pay benefits on a Secondary basis.

If an Employee works for a Group with more than twenty (20) Employees for each working day in each twenty (20) or more calendar weeks in the current or preceding benefit year, the Health Plan will be primary. However, an Employee may decline Coverage under this Health Plan and elect Medicare as Primary. In this instance, this Health Plan, by law, cannot pay benefits secondary to Medicare for Medicare covered services.

You will continue to be Covered by this Health Plan as Primary unless You:

- Notify Us, in writing, that You do not want benefits under this Health Plan; or
- Otherwise cease to be eligible for benefits under this Health Plan.

11.5.2 Failure to Enroll in Medicare Part B

If an Employee works for a Group with fewer than 20 Employees for each working day in each of twenty (20) or more calendar weeks in the current or preceding Benefit Year, and the Employee or Spouse is eligible for Medicare Part B, We will subtract the Medicare Part B benefits available whether or not the Employee or Spouse has enrolled in Medicare Part B. This means that the amount of benefit that would have been received under Medicare Part B will be subtracted from the billed amount and We will pay the remainder up to our Allowable Expense for the claim, subject to any applicable Member's Cost Share.

11.5.3 Disability

If You are under age sixty-five (65) and eligible for Medicare due to disability, and currently employed by a Group with fewer than one-hundred (100) Employees, then Medicare is the Primary payer. This Health Plan will pay benefits on a Secondary basis.

If You are age sixty-five (65) or older and actively work for a Group with at least one-hundred (100) Employees and You become entitled to benefits under Medicare due to disability (other than ESRD as discussed below), this Health Plan will be Primary for You and Your eligible Dependents and Medicare will pay benefits on a Secondary basis.

11.5.4 End Stage Renal Disease (ESRD)

If You are entitled to Medicare due to End Stage Renal Disease (ESRD), this Health Plan will be the Primary Plan for the first thirty (30) months.

11.5.5 Coordination of Benefits for Retirees (if applicable)

a) Amounts payable are paid for treatment or services by Medicare Part A and/or Part B;

b) Amounts that would have been payable (paid) for treatment or service by Medicare Part A and/or Part B, if You or Your Dependents had been covered by Medicare; or

c) Amounts paid under all other plans in which You participate.

11.6 Right of Recovery

If the amount of the payments made by Us is more than should have been paid under this COB provision, We may recover the excess from one (1) or more of the persons We paid or for whom We have paid; or any other person or organization that may be responsible for the benefits or services provided for the Covered Individual. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

11.7 Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Health Plan and other Plans. We may get the facts necessary or give them to other organizations or persons for the purpose of applying these rules and determining the benefits payable under this Health Plan and other Plans covering the person claiming benefits. We do not need to inform, or obtain the consent of, any person to do this. Each person claiming benefits under this Health Plan must give Us any facts necessary to apply these rules and determine benefits payable.

11.8 Facility of Payment

A payment made under another Plan may include an amount that should have been paid under this Health Plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Health Plan and We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

SECTION 12: TERMINATION OF COVERAGE

12.1 Termination of Coverage by Group

The Group will have the right to terminate the Agreement as specified in the Group Master Contract. The Group will notify Us if the Group determines You no longer meet eligibility requirements and Your Coverage will terminate. Such termination will be effective on the last day of the month in which such notice is received by Us, unless otherwise specified in the Group Master Contract.

12.2 Termination of Coverage by Member

The Member may terminate this Coverage for any reason during the Group open enrollment period. Termination of Coverage will be effective on the last day of the month preceding the Group Renewal Date.

12.3 Termination of Coverage by Us

We may terminate Coverage upon the occurrence of any one of the following events:

12.3.1 If We determine that You no longer meet the eligibility requirements set forth in the Agreement, including the Group Master Contract and the Evidence of Coverage, We will provide at least thirty-one (31) days notice of termination of Your Coverage. Such eligibility requirements may include, but are not limited to, living outside the Service Area for a period longer than permitted under the Agreement.

12.3.2 Nonpayment of Premiums to Health Plan or nonpayment of Member's Cost Share required for Hospital or other medical services (e.g., Copayments, Coinsurance, Deductibles). We will provide at least thirty-one (31) days notice of termination of Your Coverage. In the case of termination due to nonpayment of Premium, the termination will become retroactively effective on the day after the last day for which Premiums have been paid in full for the entire Group. Furthermore, You will be responsible for the cost of all services provided after the termination date. In the case of termination due to failure to pay supplemental charges or the Member's Cost Share, termination will become effective on the date stated in the written notice, which will be on or after the thirtieth (30th) day following the date of the notice;

12.3.3 Upon the termination or non-renewal of the Group Master Contract by the Group, as described in the Group Master Contract;

12.3.4 Immediately, if You participate in fraudulent or criminal behavior, including, but not limited to:

12.3.4.1 Performing an act or practice that constitutes fraud or an intentional misrepresentation of material fact including, but not limited to, using Your identification card to obtain goods or services which are not prescribed or ordered for You or to which You are otherwise not legally entitled must be returned to Us.

12.3.4.2 Allowing any other person to use Your identification card to obtain services. If a Dependent allows any other person to use his/her identification card to obtain services, the Coverage of the Dependent who allowed the misuse of the card will be terminated. If the Subscriber allows any other person to use his/her identification card to obtain services, the Coverage of the Subscriber and his/her Dependents will be terminated.

12.3.4.3 Threatening or perpetrating violent acts against the Health Plan, a Provider, or an Employee of the Health Plan or a Provider. In this instance, Coverage for the Subscriber and all Dependents will be terminated.

12.3.4.4 Knowingly misrepresenting or giving false information on any Enrollment Form which is material to the Health Plan's acceptance of such application.

Termination will be immediate upon Your receipt of written notice.

12.4 Effect of Termination

12.4.1 Identification cards are the property of the Health Plan and, upon request, must be returned to Us within thirty-one (31) days of the termination of Your Coverage. Identification cards are for purposes of identification only and do not guarantee eligibility to receive Covered Services.

12.4.2 Your Coverage cannot be terminated on the basis of the status of Your health or the exercise of Your rights under the Health Plan's Grievance and Complaint procedures. The Health Plan may not terminate the Agreement solely for the purpose of effecting the disenrollment of an individual Member for either of these reasons.

12.4.3 If You receive services after the termination of Coverage, the Health Plan may recover the contracted charges for such Covered Services from You or the Provider, plus Our cost to recover such charges, including attorneys' fees.

12.4.4 Under certain circumstances, You may be eligible for continuation of Coverage as described in the Continuation and Extension of Coverage Section.

12.5 Certificates of Creditable Coverage

At the time Coverage terminates, You are entitled to receive a certificate verifying the type of coverage, the date of any waiting periods, and the date any creditable coverage began and ended.

SECTION 13: CONTINUATION AND EXTENSION OF COVERAGE

13.1 Introduction

State and federal laws provide several options to continue insurance if Coverage under the Agreement is terminated.

Sometimes, an individual is eligible for more than one (1) of these protections at a time. If an individual is eligible for an extension of Coverage for more than one reason, the longest period of extension will apply. The extensions of Coverage cannot be added together to extend Coverage for a longer period of time, but will run concurrently. Similarly, if a Covered Individual qualifies for more than one type of continuation of Coverage, they will run concurrently from the date of the first qualifying event rather than being applied one after the other.

In the event a Covered Individual qualifies for an extension of Coverage, the right to continuation of Coverage must be exhausted before extension rights will apply.

If more than one (1) qualifying event occurs, only the first event applies for purposes of determining eligibility for continuation Coverage. The occurrence of a second event does not start a new or second period of continuation, but may extend the total continuation period.

13.2 Continuation Coverage Under COBRA (Consolidated Omnibus Budget Reconciliation Act)

COBRA will apply only to Groups that are subject to the provisions of COBRA. Members should contact the Group's plan administrator to determine if they are eligible to continue Coverage under COBRA.

COBRA for Members who selected COBRA under a prior plan which was replaced by Coverage under the Agreement will terminate as scheduled under the prior plan or in accordance with the terminating events set forth in Section 13.6 below.

In no event will the Health Plan be obligated to provide continuation Coverage to a Member if the Group or its designated plan administrator fails to perform its responsibilities as defined by federal law. These responsibilities include, but are not limited to, notifying the Member in a timely manner of the right to elect COBRA and notifying Us in a timely manner of the Member's election of continuation Coverage.

The Health Plan is not the Group's designated plan administrator and does not assume any responsibilities of a plan administrator pursuant to federal law.

This explanation is not a legal opinion, but merely a general summary of continuation of Coverage rights under COBRA. The Group is responsible for any administration of COBRA Coverage, if applicable. The Internal Revenue Service may change or amend COBRA from time-to-time.

13.3 Eligibility for Continuation Coverage Under COBRA

If a Member's Coverage would otherwise terminate because of one (1) of the following qualifying events, and the Group is subject to the provisions of COBRA, the Member is entitled to continue Coverage. Additional qualifying events may apply to Dependents only. Those qualifying events are listed in Section 13.5. A Member may elect the same Coverage that he or she had at the time of one (1) of the following qualifying events:

13.3.1 Termination of the Subscriber from employment with the employer or reduction of hours, for any reason other than gross misconduct;

13.3.2 Reduction in the Subscriber's scheduled work hours (e.g., change from full-time to part-time, lay off, leave of absence, etc.);

13.3.3 The Subscriber's notification to the employer of the intent not to return to work, either during or after a Family Medical Leave Act approved leave; or

13.3.4 The Group filing for bankruptcy, under Title XI, United States Code, on or after July 1, 1986, but only for a retired Subscriber and his or her enrolled Dependents. This is a qualifying event only if there is a substantial elimination of coverage within one (1) year before or after the date the bankruptcy was filed.

13.4 Election Period and Premium Requirements for Continuation Coverage Under COBRA

The Member must notify the Group's designated plan administrator within sixty (60) days of his or her divorce, legal separation or loss of eligibility as an Enrolled Dependent. Continuation must be elected by the later of sixty (60) days after the Member's qualifying event occurs, or sixty (60) days after the Member receives notice of the continuation right from the Group's designated plan administrator.

An employer may require a Member whose Coverage was terminated due to a qualifying event to pay the full cost of the COBRA Coverage. The Premium may not exceed one hundred two percent (102%) of the Premium for similarly covered Employees. The Member must pay the initial Premium due to the Group's designated plan administrator on, or no later than, the forty-fifth (45th) day after electing COBRA continuation.

13.5 Length of Coverage Under COBRA

Coverage may be continued for Subscribers and Dependents for up to eighteen (18) months. If the Subscriber is Totally Disabled at the time of the qualifying event, Coverage may be extended for up to twenty-nine (29) months.

Coverage for Dependents may be continued for up to thirty-six (36) months for the following qualifying events:

13.5.1 Death of the Subscriber;

13.5.2 Divorce or legal separation of the Subscriber;

13.5.3 Loss of eligibility by a Dependent child as a result of reaching the Limiting Age; or

13.5.4 Entitlement of the Subscriber to Medicare benefits.

13.6 Termination of Continuation Coverage Under COBRA

Continuation Coverage under COBRA will end upon the first of the following to occur:

13.6.1 The date the maximum continuation period applicable is reached;

13.6.2 Failure to make payment of the Premium when due;

13.6.3 The date coverage is obtained under any other group health plan, unless other group health coverage existed prior to COBRA eligibility. If such coverage contains a limitation or exclusion with respect to any pre-existing condition of the Health Plan Member, continuation will end on the date such limitation or exclusion ends. The other Group health coverage will be primary for all medical services except those services which are subject to the pre-existing condition limitation or exclusion;

13.6.4 The date the Member becomes entitled to Medicare, except that this will not apply in the event the Member's Coverage was terminated because the Group filed for bankruptcy, in accordance with qualifying event described in Section 13.3.4 of this Evidence of Coverage; or

13.6.5 The date the Group Master Contract terminates.

13.7 Certificates of Creditable Coverage

Certificates of creditable coverage will be sent by the Health Plan to all Members who lose Coverage under the Agreement. The following events trigger certificates of creditable coverage to be sent:

13.7.1 Upon a loss of Coverage, for any reason, under a plan, including a COBRA qualifying event;

13.7.2 Upon loss of COBRA continuation coverage; or

13.7.3 At any time upon an individual's request within twenty-four (24) months after Coverage under the Agreement ends.

13.8 Iowa Continuation Coverage

Subscribers and eligible Dependents whose Coverage under the Agreement would otherwise terminate because of the Subscriber's termination of employment may elect to continue Coverage. To continue Coverage, the Subscriber must have been continuously insured under the Agreement for the three (3) consecutive months prior to termination of employment.

Election of such coverage, along with payment in full of the first monthly Premium, must be made within ten (10) days after the Member's receipt of notice of continuation rights from the employer. In no event, however, can such election be made more than thirty-one (31) days after the date of termination.

Subscribers and eligible Dependents will not be eligible for continuation Coverage if the person:

13.8.1 Is or could be covered by Medicare; or

13.8.2 Is or is eligible to be covered by another group insured or uninsured arrangement that provides accident or health coverage (unless the person was covered by that other group policy immediately prior to the termination).

A Dependent may be eligible for continuation even if the Subscriber does not elect continuation, under one (1) of the following conditions:

13.8.3 Death of the Subscriber; or

13.8.4 Determination that the Spouse or other Dependent was the subject of abuse when Coverage was originally issued in the name of the abuser and the abuser has divorced, separated from, lost custody of the subject of abuse, or the abuser's Coverage has terminated voluntarily or involuntarily.

13.9 Termination of Iowa Continuation Coverage

Iowa continuation coverage will continue until the first of the following occurs:

13.9.1 Nine (9) months following the date the Member's Coverage would otherwise have terminated because of termination of the Subscriber's employment;

13.9.2 The date the Member becomes eligible for Medicare;

13.9.3 The date the Member becomes eligible for another group health insurance plan or uninsured arrangement, unless the Member was covered by such other arrangement immediately prior to termination;

13.9.4 The last day for which Premiums were paid in the event of a nonpayment of Premium;

13.9.5 If the Member is a former Spouse, upon the former Spouse's remarriage; or

13.9.6 The date on which the Group Master Contract terminates.

13.10 Extension of Coverage if a Member is an inpatient in a Hospital or Nursing Facility

The Health Plan will continue to provide Covered Services if the Group Master Contract terminates while a Member is an inpatient in a Hospital or skilled nursing facility. ***Services will be provided only for the specific medical condition causing that inpatient stay.*** This extension of Coverage will remain in effect until the earlier of the following:

13.10.1 The inpatient stay is no longer Medically Necessary;

13.10.2 The Member exhausts the Covered Services available for that inpatient stay and/or medical condition;

13.10.3 The Member becomes eligible for coverage from another group health benefits policy; or

13.10.4 Twelve (12) months after the termination date of the Agreement.

13.11 Extension of Coverage Upon Total Disability

The Health Plan will continue to provide Covered Services for You if You are Totally Disabled as of the date of the termination of the Agreement. This extension of Coverage will only include Covered Services that are Medically Necessary to treat medical conditions causing or directly related to the Total Disability; and will remain in effect until the earlier of the following:

13.11.1 You cease to be Totally Disabled;

13.11.2 You have exhausted the Covered Services available for treatment of that condition;

13.11.3 You become eligible for Coverage from another group health benefit plan which does not exclude Coverage for the disabling condition; or

13.11.4 Twelve (12) months from the termination date of the Agreement.

SECTION 14: COMPLAINTS AND GRIEVANCES

We maintain both informal and formal procedures to resolve Member Inquiries, Complaints, and Appeals. These processes give You the opportunity to ask Us to review any matter related to Covered Services, including, but not limited to:

- Issues about the scope of Coverage for health care services;
- Denial, cancellation, or non-renewal of Coverage;
- Denial of care, services, or claims;
- Member rights; and
- Quality of health care service received.

14.1 Procedure for Filing an Inquiry, Complaint, or Appeal

If You have a question regarding any aspect concerning Covered Services, You may contact Customer Service by telephone or in writing,.

Medical:

If You are dissatisfied with any aspect concerning medical Covered Services, You may register a Complaint or Inquiry by contacting Customer Service at the number listed on Your ID card, or in writing, expressing the details of Your dissatisfaction and to file a Complaint.

If You do not receive satisfactory resolution to a Complaint or Inquiry regarding an Adverse Benefit Determination of a health service request or benefit that You believe You are entitled to receive, You may file an Appeal or Grievance with Us at the following address or phone number:

Coventry Health Care of Iowa, Inc.
Attention: Appeals Department
P O Box 541210
Omaha, NE 68154-9210
phone: (800) 471-0240 ext. 7718
fax: (866) 769-2399

Behavioral Health:

If You are dissatisfied with any aspect concerning any Mental Disorder, Substance-Related Disorder, or Biologically Based Mental Illness related Covered Services, You may register a Complaint or Inquiry by contacting Customer Service at (800) 752-7242, or in writing, expressing the details of Your dissatisfaction and to file a Complaint.

If You do not receive satisfactory resolution to a Mental Disorder, Substance-Related Disorder, or Biologically Based Mental Illness Complaint or Inquiry regarding an Adverse Benefit Determination of a health service request or benefit that You believe You are entitled to receive, You may file an Appeal or Grievance with Us at the following address or phone number:

MHNet Behavioral Health
Attention: Appeals Department
P O Box 7811
London, KY 40742
phone: (800) 752-7242

The request for Appeal or Grievance must include Your name, Your Provider's name, the date of service, Your (or Your Authorized Representative's) mailing address, an explanation of why We should reverse Our decision, and a copy of any information that will support Your request.

The written request for an Appeal or Grievance must be filed within one hundred eighty (180) calendar days after a notice of denial (e.g., EOB for denied claims) has been received by You. Requests for Appeals or Grievances received after the one hundred eighty (180) calendar day period will not be eligible for review under Our Appeal or Grievance process.

If an Authorized Representative wishes to complete an Appeal on Your behalf, an Authorized Representative form must be completed and returned to Us. If no Authorized Representative form is completed or verbal authorization granted, an Appeal cannot be completed and any Appeal requests will be closed. If an Authorized Representative form or verbal authorization is received after an Appeal request is closed, but within one hundred eighty (180) days after notice of denial, a new Appeal will be initiated.

Upon each level of Appeal, the appropriate Health Plan staff, none of whom were involved in any of the prior Adverse Benefit Determinations or levels of Your Appeal, will review the Appeal. If the initial determination was made, in whole or in part, based on a determination of Medical Necessity, or that a service or treatment was Experimental or Investigational, the Appeal will include an evaluation by an appropriate clinical peer of the same or similar specialty as typically manages the condition, procedure or treatment being reviewed.

14.2 First Level Appeal Process

The first level Appeal gives You the right to:

- Submit supporting material; and
- Upon Your request, be provided with all relevant information that is not confidential or privileged.

Your request for Appeal will be presented for review to the First Level Appeal Committee.

14.2.1 First Level Appeal Timeframes

The first level Appeal review process will be completed in the timeframes below:

a) Pre-Service Appeals - We must resolve the Appeal and send written notification of Our decision within fifteen (15) calendar days. However, a thirty (30) calendar day extension may be granted if You or Your Authorized Representative requests such an extension.

If, for reasons beyond our control, We are unable to make a decision within fifteen (15) working days,

We will provide written notice to You by the fifteenth (15) working day, explaining the reason for the delay and advising that We will require an extension of an additional fifteen (15) working days.

b) Post-Service Appeals - We must resolve the Appeal and send written notification of Our decision within fifteen (15) business days. However, a thirty (30) calendar day extension may be granted if You or Your Authorized Representative requests such an extension.

If, for reasons beyond our control, We are unable to make a decision within fifteen (15) working days, We will provide written notice to You by the fifteenth (15th) working day, explaining the reason for the delay and advising that We will require an extension of an additional fifteen (15) working days.

c) Urgent Care/Expedited Appeals - In situations where We determine an Appeal is an Urgent Care/expedited Appeal, We will provide verbal notification to You or Your Authorized Representative of Our determination as soon as possible, taking into account the medical exigencies, but not later than thirty-six (36) hours. The Urgent Care/expedited Appeal will be reviewed by a clinical peer(s). Written confirmation of Our decision will be sent within thirty-six (36) hours of verbal notification of Our decision, so that the entire process is completed in seventy-two (72) hours. If the Urgent Care/expedited Appeal is a concurrent review determination, the health care service will be continued without liability to You until You have been notified of the determination. If the first level Appeal decision is an Adverse Benefit Determination, You may Appeal immediately to Our Second Level Appeal Committee.

14.3 Second Level Appeal Process

If You are dissatisfied with the first level Appeal determination, You may request that We review Your case a second time. Written requests for a second level Appeal must be received within sixty (60) calendar days of receipt of notice of first level Appeal determination.

The second level Appeal review process gives You the right to:

- Appear before an Appeal committee or communicate with the committee via conference call or other available technology;
- A reasonable time period to present Your case to the Appeal committee;
- Submit supporting material both before and during the committee meeting;
- Ask questions of any Appeal committee members;
- Be assisted or represented by a person of Your choice; and
- Upon Your request, be provided with all relevant information that is not confidential or privileged.

The Second Level Appeal Committee, none of whom were involved in previous decisions, will review Your concern. Proceedings of the committee are not public and will not be allowed to be recorded.

14.3.1 Second Level Appeal Timeframes

The second level Appeal review process will be completed in the timeframes below:

a) Pre-Service Appeals - We must resolve the second level Appeal and send written notification of Our decision within fifteen (15) calendar days. However, a thirty (30) calendar day extension may be granted if You or Your Authorized Representative request such an extension.

Our written decision will be issued to You within five (5) working days after the committee's decision.

b) Post-Service Appeals - We must resolve the second level Appeal and send written notification of Our decision within thirty (30) business days. However, a thirty (30) calendar day extension may be granted if You or Your Authorized Representative request such an extension.

Our written decision will be issued to You within five (5) working days after the committee's decision.

c) Urgent Care/Expedited Appeals - In situations where We determine a second level Appeal of Urgent Care/expedited Appeal, We will provide verbal notification to You or Your Authorized

Representative of Our determination as soon as possible, taking into account the medical exigencies, but not later than thirty-six (36) hours. The Urgent Care/expedited second level Appeal will be reviewed by a clinical peer(s). Written confirmation of Our decision will be sent within thirty-six (36) hours of verbal notification of Our decision, so that the entire process is completed in seventy-two (72) hours. If the Urgent Care/expedited second level Appeal is a concurrent review determination, the health care service will be continued without liability to You until You have been notified of the determination.

If You are not satisfied with the decision of Our Second Level Appeal Committee, You may pursue:

- External review as described in 14.4; or
- Normal remedies of the law not later than three (3) years after the date of notice of final determination is given.

14.4 External Review

If Your internal Appeal was not overturned either during the first level Appeal or the second level Appeal, You have received a final Adverse Benefit Determination. If Your final Adverse Benefit Determination was based on Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a Covered benefit, or that a service or treatment was Experimental or Investigational, You have a right to an external review. The external review will be performed by an independent review organization with health care professionals who have no conflict of interest with respect to the benefit determination.

If You or Your Authorized Representative wish to seek an independent external review of Our final Adverse Benefit Determination, You may file a written request within four (4) months of the date You received notice of the final Adverse Benefit Determination.

The request must be sent in writing to:

Iowa Department of Insurance
330 Maple Street
Des Moines, IA 50319
(515) 281-5705) or
(877) 955-1212

You will be notified in writing by the external reviewer of the final external review decision within forty-five (45) days from the date the request for external review is received. We will receive a copy of this notice as well. The final external review decision is binding on both You and Us, unless there are other remedies available under state or federal law.

Expedited External Review: You or Your Authorized Representative may request an expedited external review if You have completed an internal Urgent Care Appeal and the Adverse Benefit Determination involves a medical condition for which the timeframe for completion of an internal Urgent Care Appeal would seriously jeopardize Your life or health; or would jeopardize Your ability to regain maximum function; or if the Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which You received services, but have not been discharged from a facility. You will be notified by the external reviewer of the expedited external review decision within seventy-two (72) hours from the time the request for external review was received. We will be notified of the decision as well. The final external review decision is binding on both You and Us, unless there are other remedies available under state or federal law.

14.5 Department of Insurance Review

In case of a dispute about any part of the Agreement or if You encounter situations where the performance of the Health Plan does not meet Your expectations, You may contact the Iowa Department of Insurance at:

Iowa Insurance Division
330 Maple Street
Des Moines, IA 50319
(515) 281-5705 or
(877) 955-1212

SECTION 15: CONFIDENTIALITY OF YOUR MEDICAL RECORDS

As part of the Agreement, You agree to provide Us access to any records and medical information held by any Provider of Covered Services. You also give Us, Our representatives, and authorized regulators or accrediting bodies access to Your general medical records for:

- Claims processing, including claims decisions We make on Your behalf for reimbursement;
- Quality assessment and improvement;
- Medical case management;
- Underwriting (for reinstating or adding a Dependent); or
- Evaluation of potential or actual claims against Us.

To best serve You, We need information about You. This information may come from You, the Group, or other health benefits plan sponsors. Examples include Your name, address, date of birth, marital status, employment information, or medical history. We also receive information from Providers about the health care services You receive. This information may be in the form of health care claims and encounters, medical information, or a service request.

We maintain policies regarding confidentiality, protection and disclosure of Your nonpublic personal information, including policies related to access to medical records. We may collect, use or share nonpublic personal information to perform Our health care operations, arrange for Your treatment, to pay Your claims or for other purposes permitted or required by law. Nonpublic personal information will not be released to third parties including Your employer, researchers or the government without Your or Your Authorized Representative**'**s consent, except as may be permitted or required by law.

If You have any questions about Our policies or procedures to maintain the confidentiality of nonpublic personal information, please contact Customer Service.

SECTION 16: RIGHT OF RECOVERY (THIRD PARTY LIABILITY SUBROGATION)

If You have a legal right to receive payment from an individual or organization because another party was responsible for Your illness, injury or other loss, We have a right of subrogation, subject to any restrictions imposed by applicable state law and upon Your full compensation, to any funds recovered as a result of this right. In other words, if You accept coverage for Covered Services under the Agreement, You must agree to reimburse Us in full for any benefits paid from any settlement, judgment or other payment You or Your attorney may receive specifically for medical expenses as a result of Your personal injury. We will only be entitled to recovery after You have been fully compensated.

You are obligated to cooperate with Us to protect Our subrogation rights. This cooperation includes: providing Us with relevant information, signing and delivering documents We reasonably request, and obtaining Our consent before releasing any party from liability. If You enter into litigation or settlement negotiations regarding the obligations of other parties, You must not prejudice, in any way, Our rights under subrogation proceedings. You or Your attorney must inform Us of any legal action or settlement agreement at least ten (10) days prior to settlement or trial. The costs of Our legal representation in matters related to subrogation will be borne solely by Us. The costs of Your legal representation will be borne solely by You.

SECTION 17: GENERAL PROVISIONS

17.1 Applicability

The provisions of the Agreement will apply equally to the Subscriber and Covered Dependents and all benefits and privileges made available the Subscriber will be available to Covered Dependents.

17.2 Choice of Law

The Agreement will be administered under the laws of the State of Iowa.

17.3 Clerical Error

Clerical error relating to the Coverage under the Agreement will not invalidate Coverage otherwise validly in force nor continue Coverage otherwise validly terminated.

17.4 Conflicts with Existing Laws

If any provision of the Agreement conflicts with state or federal law, that law will pre-empt only that provision of the Agreement that is in conflict. If any provision of the Agreement conflicts with the requirements of state or federal law, the Agreement will be administered in such a way as to comply with the requirements of the law, and will be deemed amended to conform with the law. The Agreement will be amended as required.

17.5 Entire Agreement

The written Agreement will constitute the entire Agreement between the parties. No change to the Agreement will be valid until approved by an Officer of the Health Plan and such approval is endorsed hereon or attached hereto. No agent has authority to change the Agreement or waive any of its provisions.

17.6 Time Limit on Certain Defenses

All statements, in the absence of fraud, pertaining to coverage under the Agreement that are made by You will be deemed representations, but not warranties. After two (2) years from the date of issue of the Agreement, no misstatements, except fraudulent misstatements, made by You will be used in any context to void the coverage, or to reduce or deny benefits.

17.7 Legal Actions

No action at law or in equity will be brought to recover on the Agreement prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of the Agreement. No such action will be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

17.8 Nontransferable

No person other than You or Your Dependents is entitled to receive health care service coverage or other benefits to be furnished by Us under the Agreement. Such right to health care service coverage or other benefits is not transferable.

17.9 Relationship Among Parties Affected by Agreement

The relationship between the Health Plan and Participating Providers is that of independent contractors. Participating Providers are not agents or employees of the Health Plan, nor is the Health Plan or any employee of the Health Plan an employee or agent of Participating Providers. Participating Providers will maintain the Provider-patient relationship with You and are solely responsible to You for all Participating Provider services.

Neither the Group nor You is an agent or representative of the Health Plan, and neither will be liable for any acts or omissions of the Health Plan for the performance of services under the Agreement.

17.10 Reservations and Alternatives

We reserve the right to contract with other corporations, associations, partnerships, or individuals for the furnishing of any of the services or benefits described herein.

17.11 Severability

In the event that any provision of the Agreement is held to be invalid or unenforceable for any reason, the invalidity or unenforceability of that provision will not affect the remainder of the Agreement, which will continue in full force and effect in accordance with its remaining terms.

17.12 Valid Amendment

No change in the Agreement will be valid unless approved by an Officer of the Health Plan, and evidenced by endorsement on this Evidence of Coverage and/or by Amendment to the Agreement. Such Amendment will be incorporated into this Evidence of Coverage when applicable.

17.13 Waiver

The failure of the Health Plan, the Group, or You to enforce any provision of the Agreement will not be deemed or construed to be a waiver of the enforceability of such provision. Similarly, the failure to enforce any remedy arising from a default under the terms of the Agreement will not be deemed or construed to be a waiver of such default.

17.14 Value Added Services

From time to time We may offer to provide Members access to discounts on health care related goods or services. While We have arranged for access to these goods, services and/or third party provider discounts, the third party service

providers are liable to the Members for the provision of such goods and/or services. We are not responsible for the provision of such goods and/or services nor are We liable for the failure of the provision of the same. Further, We are not liable to the Members for the negligent provision of such goods and/or services by third party service providers. These discounts are subject to modification or discontinuance without notice.

17.15 Discounts and Rebates

Member understands and agrees that the Health Plan may receive a retrospective discount or rebate from a Participating Provider or vendor related to the aggregate volume of services, supplies, equipment or pharmaceuticals purchased by persons enrolled in health care plans offered or administered by Health Plan and its affiliates. Member will not share in such retrospective volume-based discounts or rebates. However, such rebates will be considered, in the aggregate, in Health Plan's prospective Premium calculations.

17.16 Overpayments

In the event We make an overpayment, including, but not limited to, payment of claims submitted for dates of service following termination of Your Coverage, We have the right to recover any overpayments paid directly to You as the result of fraud, misrepresentations, and Our error. Upon Our request, You must promptly reimburse Us in the amount of any excess benefit You have received. If such payments are not refunded within thirty (30) days of Our written request for such refund, We may take appropriate action to collect these funds.

We will not withhold any benefits payable to correct an overpayment unless:

17.16.1 We have clear evidence of overpayment and written authorization to withhold such benefits; or

17.16.2 We have clear evidence of overpayment and all of the following:

17.16.2.1 The overpayment was erroneous under the provisions of the Agreement and not a mistake of law;

17.16.2.2 We notify the claimant within six (6) months of the date of the error, except that in instances of error prompted by representations or nondisclosures of claimants, We notify the claimant within fifteen (15) days after the date that clear, documented evidence of discovery of such error is included in Our file; or

17.16.2.3 Our notice to the claimant clearly states the nature of the error, the amount of the overpayment, and the three (3) year limitation upon withholdings.

In no event will We withhold benefits to correct an overpayment after three (3) years from the date of overpayment.

17.17 Discretionary Authority

We have the sole discretionary authority to interpret the Subscriber's Health Plan in order to make eligibility and benefit determinations. We also have the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Agreement.

17.18 Policies and Procedures

We may adopt policies, procedures, rules and interpretations to promote orderly and efficient administration of this Evidence of Coverage.

SECTION 18: SERVICE AREA DESCRIPTION

In Iowa: Adair; Appanoose; Benton; Black Hawk; Boone; Bremer; Buchanan; Buena Vista; Butler; Calhoun; Carroll; Cass; Cedar; Cerro Gordo; Cherokee; Chickasaw; Clarke; Crawford; Dallas; Davis; Decatur; Delaware; Dickinson; Emmet; Fayette; Floyd; Franklin; Fremont; Greene; Grundy; Guthrie; Hamilton; Hancock; Hardin; Harrison; Howard; Humboldt; Ida; Iowa; Jasper; Johnson; Jones; Keokuk; Kossuth; Linn; Lucas; Lyon; Madison; Mahaska; Marion; Marshall: Mills; Mitchell; Monona; Monroe; Montgomery; Muscatine; O'Brien; Osceola; Page; Palo Alto; Plymouth; Pocahontas; Polk; Pottawattamie; Poweshiek; Ringgold; Sac; Scott; Shelby; Sioux; Story; Tama; Union; Warren; Washington; Wayne; Webster; Winnebago; Winneshiek; Woodbury; Worth; Wright.

SECTION 19 : IMPORTANT ADDRESSES AND PHONE NUMBERS

Medical

To submit a medical claim, general correspondence, questions regarding claims processing, or to file a written Complaint:

Coventry Health Care of Iowa, Inc.
P O Box 7709
London, KY 40742-7709

To contact Customer Service to verify eligibility and/or benefits, to check status of a medical claim, or to file a verbal Complaint: (800) 257-4692.

For Prior Authorization: (800) 470-6352 ext. 4013272.

For Urgent Care Out-of-Network, call the number on Your member ID card.

To file an Appeal or Grievance regarding a medical claim:

Coventry Health Care of Iowa, Inc.
Attention: Appeals Department
P O Box 541210
Omaha, NE 68154-9210
(800) 471-0240 ext. 7718

Behavioral Health

To submit a Mental Disorder, Substance-Related Disorder, or Biologically Based Mental Illness claim, or questions regarding claims processing:

MHNet Behavioral Health
P O Box 7802
London, KY 40742-7705

To submit general correspondence:

MHNet Behavioral Health
P O Box 209010
Austin, TX 78720-9010

To contact Customer Service to verify Mental Disorder, Substance-Related Disorder, or Biologically Based Mental Illness benefits, to check status of a mental health claim, or to file a verbal Complaint: MHNet Behavioral Health: (800) 752-7242.

For Prior Authorization: (800) 752-7242.

To file an Appeal, Grievance, or written Complaint regarding a Mental Disorder, Substance-Related Disorder or Biologically Based Mental Illness claim:

MHNet Behavioral Health
Attention: Appeals Department
P O Box 7811
London, KY 40742
(800) 752-7242

Pharmacy

To file a pharmacy claim:

Medco
P O Box 659574
San Antonio, TX 78265-9574
(800) 378-7040

Please visit Us at www.chciowa.com.

A copy of the American Academy of Pediatrics recommendations for childhood immunizations may be obtained through:

American Academy of Pediatrics
141 Northwest Point Boulevard, P O Box 927
Elk Grove Village, IL 60009-0927

COVENTRY
Health Care of Iowa, Inc.

AMENDMENT

Purpose of Amendment:

This Amendment is an attachment to Your Agreement. The information explained in this Amendment modifies the terms of the Agreement under which You are enrolled to receive benefits. Please keep this Amendment with the Evidence of Coverage as it becomes part of Your Agreement.

This Amendment is effective on the later of August 1, 2012 or Your Member Effective Date. This Amendment ends when Coverage under the Agreement ends.

Capitalized terms used in this Amendment and not defined herein shall have the meaning set forth in the Evidence of Coverage.

Nothing in this Amendment shall be held to vary, alter, waive or extend any of the terms, conditions, provisions, agreements or limitations of the Agreement, other than as specifically stated below. In the event of a conflict between the terms and conditions of this Amendment and the Agreement or Schedule of Benefits, the terms and conditions of this Amendment shall control.

Amendments to the Agreement:

1) The section of the Evidence of Coverage titled "8.1 Table of Covered Services is amended as follows:

- The section of the table titled "Maternity Services" is hereby amended to allow coverage for manual breast pumps.
- The section of the table titled "Preventive Services" is hereby deleted in its entirety and replaced with the following:

Preventive Services (as such term is defined in Section 1.)	Covered Services for:
	• Routine physical examination, including laboratory tests and x-rays;
	• Well-child care, from birth to age eighteen (18) for certain well-child care services as defined by the U.S. Preventive Services Task Force and Advisory Committee on Immunization Practices. Such well-child care includes a history and complete physical examination as well as developmental assessment, anticipatory guidance, immunizations, vision and newborn hearing screening, and laboratory services including, but not limited to, screening for lead exposure as well as blood levels;
	• PSA test, one in a twelve (12) month period and digital rectal examinations, all in accordance with American Cancer Society Guidelines;
	• Colon cancer screening (Please refer to the "Colon Cancer Screening" benefit for details);
	• Well-woman care, including one pap smear in a twelve (12) month period;
	• Screening mammography (Please refer to the "Mammograms" benefit for details);
	• Well-woman care, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. Such well-woman care includes:
	  • Breast-feeding support, supplies, and counseling, including a manual breast pump;
	  • Contraceptive methods and counseling;
		Limitations:
		Preventive care does not include any service or benefit intended to treat an existing illness, injury or condition.
		Please note that some Covered Services You receive during a preventive care office visit may not qualify as preventive care under this section.
		Please refer to Your Schedule of Benefits to determine if preventive services, described under the Covered Services Section of the Agreement, are exempt from any Deductible.
		Exclusions:
		Tobacco cessation treatment and prescription and over-the-counter products used to quit tobacco usage;
		Electric breast pump; or
		Prescription contraceptives, unless covered in an Outpatient Prescription Drug Rider included in the Agreement.

	• Counseling for sexually transmitted infections, one counseling session in a twelve (12) month period; • Counseling and screening for human immune-deficiency virus, one counseling session and screening in a twelve (12) month period; • Human papilloma virus testing, one test every three (3) years; • Screening for gestational diabetes; and • Screening and counseling for interpersonal and domestic violence, one counseling session and screening in a twelve (12) month period. • Counseling for tobacco use and tobacco-caused disease. The Provider must bill/code services as preventive in order for the Preventive Services benefit to apply.	

2) Exclusion **9.2.18**, of the section titled "**9.2 SPECIFICALLY EXCLUDED**" is hereby deleted in its entirety and replaced with the following:

"9.2.18 Electric Breast pumps;"

3) The following section of the Schedule of Benefits is amended as follows:

COVERED SERVICES	**MEMBER RESPONSIBILITY**	
	In-Network	**Out-of-Network**
Family Planning Services • Elective Sterilization, women	Copay, Deductible and Coinsurance Waived	See Schedule of Benefits for applicable Member Cost Share

COVENTRY HEALTH CARE OF IOWA, INC.

CHIEF EXECUTIVE OFFICER

COVENTRY Health Care of Iowa, Inc.	**HMO Open Access** **Schedule of Benefits** Citigroup

Benefits	**Member Responsibility** **In-Network**
"Benefit Year" means a calendar year, which is the period of twelve (12) consecutive months commencing on January 1st and continuing through December 31st of that year.	
Deductible (Per Benefit Year) • Individual Deductible • Family Deductible	$500 $1,000
Coinsurance	10%
Out-of-Pocket Maximum (Per Benefit Year) **The Out-of-Pocket Maximum** includes Deductible and Coinsurance. • Individual • Family	$3,000 $6,000
Maximum Lifetime Benefit (while covered under the Health Plan)	Unlimited

Covered Services	**Member Responsibility** **In-Network**
Preventive Services	
For services billed as routine including physicals, laboratory, well-baby care, well-child care, well-woman care, mammograms, prostate cancer screening, colon cancer screening, diabetes screening, certain osteoporosis screenings, behavioral health screening, flu shots, and adult and childhood immunizations	$0 Copayment
Physician Office Services	
Primary Care Physician (PCP) Office Visit* For non-Preventive Services billed by a Physician's office including: • Non-routine laboratory and radiology services • Allergy Injections • Allergy Testing • Convenient Care Clinic • Surgery performed in Physician's office	Deductible then Coinsurance
Specialist Physician Office Visit For non-Preventive Services billed by a Physician's office including: • Non-routine laboratory and radiology services • Allergy Injections • Allergy Testing • Surgery performed in Physician's office	Deductible then Coinsurance

Covered Services	Member Responsibility In-Network
Maternity Services	
Includes prenatal, delivery and postnatal physician services and office visits. For Hospital charges related to delivery or other inpatient Hospital care, refer to Member Responsibility for "Inpatient Hospital." Member Responsibility for 1st visit only	Deductible then Coinsurance
Urgent Care Facility	
	Deductible then Coinsurance
Outpatient Facility	
For non-Preventive Services including: • Services performed at a Hospital or Free-Standing Facility • Non-routine laboratory, radiology and diagnostic testing services	Deductible then Coinsurance
Emergency Services	
Hospital Emergency Room (Copayment waived if admitted to the hospital)	$100 Copayment
Ambulance	Deductible then Coinsurance
Inpatient Hospital Services	
• Inpatient hospital care, including semi-private room & board, intensive / coronary care, maternity care, x-ray, laboratory and other facility and ancillary charges	Deductible then Coinsurance
Short Term Therapies	
Speech Therapy Coverage for up to 20 visits per Benefit Year	Deductible then Coinsurance
Occupational Therapy Coverage for up to 20 visits per Benefit Year	Deductible then Coinsurance
Physical Therapy Coverage for up to 20 visits per Benefit Year	Deductible then Coinsurance
Cardiac/Pulmonary Rehabilitation Coverage for up to 36 visits per Benefit Year for all Cardiac and Pulmonary Rehabilitation combined.	Deductible then Coinsurance
Manipulative Therapies	
Spinal Manipulation Coverage for up to 18 visits per Benefit Year.	Deductible then Coinsurance
Other Manipulative Therapies	Deductible then Coinsurance
Other Services	
Family Planning • Elective Sterilization, Male or Female	Deductible then Coinsurance
• Infertility Diagnosis only	Deductible then Coinsurance
• Infertility Treatment	No Coverage
Nursing Facility/Nursing Care Coverage up to 60 days per Benefit Year	Deductible then Coinsurance
Home Health Care Coverage up to 60 visits per Benefit Year	Deductible then Coinsurance
Hospice Care • Inpatient • Outpatient	Deductible then Coinsurance Deductible then Coinsurance

Covered Services	Member Responsibility In-Network
Durable Medical Equipment (DME)	Deductible then Coinsurance
Oxygen	Deductible then Coinsurance
Prosthetic Devices • Arm or Leg, in whole or in part • Other Prosthetic Devices	Deductible waived, then Coinsurance Deductible then Coinsurance
Transplant Services Must be performed at a Coventry Transplant Network Facility approved by Us	Copayments, Deductible and Coinsurance apply as specified in this Schedule of Benefits, based on place and type of services rendered.
Outpatient Prescription Drugs	Covered if Outpatient Prescription Drug Rider is attached to Evidence of Coverage. If applicable, refer to Outpatient Prescription Drug Rider for benefit details.
Mental Disorder, Substance-Related Disorder, and/or Biologically Based Mental Illness Coverage (with the exception of certain screenings)	Covered if Rider is attached to Evidence of Coverage. If applicable, refer to the Rider for Mental Disorder, Substance-Related Disorder and/or Biologically Based Mental Illness for benefit details.

* Primary Care Physicians ("PCP") generally include those Physicians who practice in the specialties of Family Practice, Internal Medicine, General Practice, OB/GYN or Pediatrics. If You are not sure if a Physician is a PCP, please contact the Customer Service Number on the back of your ID card. If you receive a service from a PCP, your PCP Member Responsibility will apply. If you receive this service from a Specialist, your Specialist benefit will apply.

Only services and treatments that meet both Our Medical Necessity criteria and are listed as a Covered Service in the Agreement will be Covered. Services and treatments listed under the Exclusions and Limitations Section are not Covered, regardless of Medical Necessity. Even though your Provider may recommend a procedure, service, or supply, the care may not always be Medically Necessary. See your Evidence of Coverage (EOC) for further details on Medical Necessity, Covered Services and a listing of Exclusions and Limitations.

Some Covered Services that You receive during a Preventive Services visit may not qualify as Preventive Services under the Agreement and, consequently, will be subject to applicable Copayment, Coinsurance and/or Deductible.

It is Your obligation to ensure that any required Prior Authorization has been obtained. Before you receive certain services, supplies, or procedures, You or Your Participating Physician must request any necessary Prior Authorization. If You choose to have requested services performed even though We were unable to certify the Medical Necessity of the services, You will be responsible for the charges.

If you are unsure if a service requires Prior Authorization, contact Us at the Customer Service phone number listed on the back of your ID card prior to receiving care.

This Schedule is part of Your Evidence of Coverage (EOC) but does not replace it. Many words are defined elsewhere in the EOC and other limitations or exclusions may be listed in other sections of your EOC. Reading this Schedule by itself could give you an inaccurate impression of the terms of Your Coverage. This Schedule must be read with the rest of Your EOC. A complete list of Covered Services, Exclusions, and Limitations can be found in Your EOC.

COVENTRY
Health Care of Iowa, Inc.

OUTPATIENT PRESCRIPTION DRUG RIDER

This Rider is made a part of the Evidence of Coverage (EOC). In case of any conflict between the terms or provisions of this Rider and the EOC, this Rider controls.

The benefits provided by this Rider become effective on the Member Effective Date or the date this Rider was purchased, whichever is later. The benefits provided by this Rider end when this Rider terminates or when Coverage under the Agreement ends.

All definitions, provisions, terms, limitations, exclusions, and conditions of the EOC apply to this Rider except to the extent such terms and conditions are explicitly superseded or modified by this Rider. Any capitalized terms used in this Rider and not otherwise defined herein will have the meaning set forth in the EOC. The plural or singular version of each defined word or phrase will apply the same definition.

Coverage of a Prescription Drug does not constitute any assumption of liability for treatment of a sickness, injury, or condition, not otherwise Covered in the EOC.

SECTION 1: COVERED SERVICES

Subject to the Limitations, Exclusions, Member Responsibility, and Ancillary Charges described below, outpatient Prescription Drugs will be Covered under this Rider when:

a. You are eligible to receive Covered Services and present Your current identification card to a pharmacy;

b. Your Prescription Order or Refill is written by a Prescribing Provider; and

c. When filled at a Participating Pharmacy, including a Maintenance Medication Pharmacy or Specialty Pharmacy.

Generically equivalent pharmaceuticals will be dispensed whenever there is an FDA approved Generic drug. If You receive a brand name Prescription Drug when a Generic drug is available, You will be responsible for the Ancillary Charge in addition to Your applicable Member Responsibility. The Ancillary Charge will apply regardless of whether or not the Prescribing Provider indicates that the pharmacy is to "Dispense as Written." Your total Member Responsibility will not exceed the average wholesale price of the Prescription Drug plus dispensing fee.

1.1 Table of Covered Services

	Member Responsibility	
Medically Necessary Covered Services	**Participating Pharmacy**	**Non-Participating Pharmacy**
Tier 0 Value Formulary Prescription Drugs	$0 Copayment 3 fill or refill maximum	Not Covered
Tier 1 Generic Formulary Prescription Drugs	$10 Copayment	Not Covered
Tier 2 Brand Formulary Prescription Drugs	$20 Copayment	Not Covered

	Member Responsibility	
Medically Necessary Covered Services	**Participating Pharmacy**	**Non-Participating Pharmacy**
Tier 3 Non-Formulary Prescription Drugs	$45 Copayment	Not Covered
Specialty Drugs	$10 Copayment for Tier 1 $20 Copayment for Tier 2 $45 Copayment for Tier 3	Not Covered
Oral Chemotherapy Drugs with IV Equivalents	$0 Copayment	20% Coinsurance
Maintenance Medication *May be dispensed up to a 93 day supply*	$20 Copayment for Tier 1 $40 Copayment for Tier 2 $135 Copayment for Tier 3	Not Covered

1.2 Member Responsibility

Payments You make for Covered Services described in the above table of Covered Services do not count toward and are separate from any Deductible and Out-of-Pocket Maximums under the medical Health Plan. The Deductible and Out-of-Pocket Maximum amounts for the medical Health Plan are listed in Your Schedule of Benefits.

SECTION 2: BENEFIT INFORMATION

2.1 The following rules apply to Prescription Orders and Refills:

2.1.1 Member Responsibility is due each time a Prescription Drug order is filled or refilled up to a thirty-one (31) day supply at a retail Participating Pharmacy or up to a ninety-three (93) day supply at a mail order pharmacy.

2.1.2 Select over-the-counter medications as determined by the Health Plan to be equivalent to prescription dosage strength will be Covered under this Rider for the appropriate Tier 1 Formulary Member Responsibility. Coverage of the selected over-the-counter medications requires a Provider's prescription.

2.1.3 Only one drug and "Rx Unit" will be dispensed per Prescription Drug fill or refill. The Rx Unit quantity is determined by FDA labeling, the dosage required or the Health Plan Formulary guidelines. Member Responsibility is required for each Rx Unit, Dispensed Container, or prepackaged item.

2.1.4 If a Prescription Drug is prescribed in a single dosage amount but the version of that Prescription Drug on the Formulary is not manufactured in such single dosage amount, then the Member Responsibility will be the same as if the Formulary Prescription Drug was manufactured in such single dose.

2.1.5 Members presently taking a Formulary Prescription Drug will be notified either electronically, or in writing at least thirty (30) days prior to any deletions to the Formulary. Notifications will not be provided for generic substitutions or drugs provided free of charge to the member by the manufacturer.

2.1.6 The Health Plan may provide Coverage for any drug dispensed in the original manufacturer packaging which contains a ninety (90) day or twelve (12) week supply or that has a duration of action of twelve (12) weeks or longer upon payment of three (3) Copayments, including, but not limited to Depo-provera and Seasonale.

2.2 Retail Participating Pharmacy Benefits

Prescription Drugs not ordered through a Maintenance Medication Pharmacy or Specialty Pharmacy may be obtained at a retail Participating Pharmacy. Prescription Drugs filled at a retail Participating Pharmacy are generally limited to a thirty-one (31) day supply per fill. However, the following may be dispensed at up to a ninety-three (93) day supply:

2.2.1 Insulin and diabetic supplies (insulin syringes, with or without needles, needles, blood and urine glucose test strips, lancets and devices, ketone test strips and tabs).

2.2.2 Oral contraceptives.

2.3 Maintenance Medication or Mail Order Benefits

Prescription Drugs determined by the Health Plan to be Maintenance Medications can be filled by the Maintenance Medication Pharmacy at up to a ninety-three (93) day supply. Maintenance Medication Pharmacies generally fill a Prescription Order or Refill by mail and may be referred to as mail order pharmacies. To access a mail order Maintenance Medication Pharmacy, the Member will mail the Prescription Order or Refill to the Maintenance Medication Pharmacy in the designated mail order prescription envelope available on our website www.chciowa.com. In most circumstances, the Member Responsibility is due at the time the order is placed.

2.4 Specialty Pharmacy Benefits

Self-Administered Injectable Drugs and Specialty Drugs are Covered under this Rider only when they are obtained from a Specialty Pharmacy. Your Prescribing Provider will receive instructions on how to initiate the process with the Specialty Pharmacy when Prior Authorization is obtained. You may also contact Customer Service at the phone number listed on Your ID card for additional support. Specialty Drugs are listed on:

2.4.1 The Specialty Medication List; and

2.4.2 Tier 1, Tier 2 and Tier 3 throughout the Formulary, identified with a (SP).

2.5 Value Formulary Benefits

Members that appear to meet the Health Plan's criteria for Value Formulary benefits (as such information is available in the Health Plan's claim records) will be notified that they qualify for a Value Formulary Prescription Drug benefit, when such drugs are temporarily added. Please note, just because a Member fills a prescription for a Value Formulary Prescription Drug does not mean the Member qualifies for the Value Formulary benefit. Rather, only Members that meet the Health Plan criteria will receive the Value Formulary benefit.

There may be instances where a drug is listed as a Value Formulary Prescription Drug and on the Tier 1 or Tier 2 Formulary. If a Member does not satisfy the Health Plan's Value Formulary criteria, the Prescription Drug will be subject to the Tier 1 or Tier 2 Formulary Member Responsibility, as applicable.

2.6 Non-Participating Pharmacy Benefits

A Prescription Order or Refill may be obtained through a Non-Participating Pharmacy, however, You may be required to pay for the entire cost of the Prescription Drug(s).

Prescription Drugs prescribed for Emergency Medical Conditions and filled by a Non-Participating Pharmacy are Covered, in full, only if a Participating Pharmacy was not available.

2.7 Prior Authorization Requirements

Regardless of where a Prescription Order or Refill is filled, some drugs require Prior Authorization or Step Therapy in order for them to be Covered. These include, but are not limited to, medications that require special medical tests before use, that are not recommended as a first-line treatment, or that have a potential misuse or abuse. Prescription Drugs requiring Prior Authorization are identified within the Formulary with "PA" next to the name of the drug. Prescription Drugs requiring Step Therapy are identified within the Formulary with "ST" next to the name of the drug.

If You use a Non-Participating Provider, it is Your responsibility to contact the Health Plan before the Prescription Order or Refill is filled to obtain any required Prior Authorization. If the Health Plan is not contacted for Prior Authorization, You may be required to pay one hundred percent (100%) of the cost for a Prescription Drug.

2.8 Narcotic Safety Program

The Health Plan reserves the right to implement quality programs related to narcotic utilization. This may include imposing Prior Authorization requirements, limiting access to narcotics to a specific provider or providers or other limitations (including non-coverage) as determined by Us.

2.9 Quantity Limits

There are general limits on how much of a Prescription Drug may be dispensed by a pharmacy to fill a Prescription Order or Refill. Unless otherwise provided by this Rider, the quantity of a Prescription Drug should not exceed that required for the lesser of:

2.9.1 The quantity prescribed in the Prescription Order or Prescription Refill;

2.9.2 A thirty-one (31) day supply, excluding Maintenance Medication Pharmacies;

2.9.3 The amount determined by Us to be Medically Necessary; or

2.9.4 Depending on the form and packaging of the product, the following: The number of commercially prepackaged items (including but not limited to inhalers, topicals, and vials) needed for thirty-one (31) days of treatment with Member Responsibility applied to each pre-packaged item or container.

To promote appropriate utilization, or following manufacturer's recommendations, some Covered Drugs under this Rider may also be subject to Prescription Drug specific quantity limits. You can get information on specific quantity limits from the searchable Formulary on the website www.chciowa.com or by contacting Customer Service at the telephone number on Your ID card. A hard-copy of the Formulary is available upon request. Before a Prescription Order or Refill for a drug that exceeds the specific quantity limit can be filled, the Prescribing Provider must call the Health Plan and obtain Prior Authorization.

SECTION 3: LIMITATIONS

3.1 A Prescription Order or Refill will not be provided after the lesser of:

3.1.1 Twelve (12) months from the original date on the Prescription Order or Refill; or

3.1.2 The period of time limited by state or federal law.

3.2 Contraceptive diaphragms prescribed by a Prescribing Provider are limited to two (2) per year.

3.3 Coverage of injectable drugs is limited to Self-Administered Injectable Drugs as determined by the Health Plan and insulin, glucagon, bee sting kits, Imitrex and injectable contraceptives that are commonly and customarily administered by the Member.

3.4 Coverage of therapeutic devices or supplies requiring a Prescription Order and prescribed by a Prescribing Provider is limited to Health Plan approved devices, supplies, or spacers for metered dose inhalers.

3.5 Coverage through a mail order Maintenance Medication Pharmacy is not available on drugs that cannot be shipped by mail due to state or federal laws or regulations, or when the Health Plan considers shipment through the mail to be unsafe. Examples of these types of drugs include, but are not limited to, narcotics, amphetamines, DEA controlled substances or anticoagulants.

3.6 Selected products with narrow therapeutic index, potential for misuse and/or abuse, high cost, or a narrow or limited range of Food and Drug Administration approved indications may require Prior Authorization by the Health Plan and may not be available through the Maintenance Medication Pharmacy program.

3.7 The Health Plan reserves the right to include only one dosage or form of a drug on Our Formulary when the same drug (e.g. a drug with the same active ingredient) is available in different dosages or forms (e.g., dissolvable tablets, capsules, etc.) from the same or different manufacturers. The product, in the dosage or form that is listed on the Formulary will be Covered at the appropriate Member Responsibility. The product or products in forms or dosages not listed on the Formulary will not be Covered.

3.8 The Health Plan reserves the right to include only one (1) Prescription Drug on its Formulary when the same Prescription Drug is made or sold under two or more different names. The Prescription Drug that is listed on the Formulary will be Covered in accordance with the level on which it is listed on the Formulary. The Prescription Drug(s) that is/are not listed on the Formulary will not be Covered.

3.9 The pharmacy will not dispense a Prescription Drug order which, in the Pharmacist's professional judgment, should not be filled.

3.10 The number of doses of a Prescription Drug that are Covered during the last two (2) months of the Agreement may be limited to an amount sufficient to last only until the termination of the Agreement.

SECTION 4: EXCLUSIONS

The following are excluded from Coverage under this Rider:

4.1 Anti-smoking or tobacco cessation medications or devices.

4.2 Any Prescription Drug which is to be administered, in whole or in part, while You are in a Hospital, Physicians office or other health care facility.

4.3 Compounded prescriptions, unless all of the following apply:

4.3.1 There is no suitable commercially-available alternative available;

4.3.2 The main active ingredient is a Covered Prescription Drug;

4.3.3 The purpose is solely to prepare a dose form that is Medically Necessary and is documented by the Prescribing Provider; and

4.3.4 The claim is submitted electronically by the pharmacy.

4.4 Devices or supplies of any type, even though requiring a Prescription Order, including but not limited to, therapeutic devices, support garments, corrective appliances, non-disposable hypodermic needles, syringes or other devices, regardless of their intended use.

4.5 Drugs, oral or injectable, used for the primary purpose of, or in connection with, treating infertility, fertilization, and/or artificial insemination, except as specifically Covered under a separate Rider.

4.6 Drugs that do not require a prescription by federal or state law, that is, over-the-counter drugs or over-the-counter products, unless specifically designated for Coverage on the Formulary and obtained from a pharmacy with a Prescribing Provider's prescription. Also excluded are Prescription Medications that have an over-the-counter equivalent or alternatives, unless otherwise specified on the Formulary.

4.7 Drugs used primarily for hair restoration.

4.8 Duplicate drug therapy (e.g., two antihistamine drugs).

4.9 Extemporaneous dosage forms of natural estrogen or progesterone; or any natural hormone replacement product, including, but not limited to, oral capsules, suppositories, creams and troches.

4.10 Injectable medications and Specialty Drugs, except those designated by the Health Plan.

4.11 Implantable time-released Prescription Drugs (e.g., Eligard or Zoladex).

4.12 Medications, oral or injectable, used for Cosmetic purposes, including, but not limited to, medications to enhance athletic performance or to slow or reverse the normal aging process (e.g., anabolic steroids, growth hormone, testosterone, minoxidil lotion, retin A (tretinoin) for aging skin, etc.).

4.13 Oral dental preparations and fluoride rinses, except pediatric fluoride tablets or drops as specified on the Formulary.

4.14 Pharmacological therapy for weight reduction, dietary supplements, appetite suppressants, and other drugs used to treat obesity, morbid obesity or assist in weight reduction.

4.15 Prescription Drugs dispensed in unit doses when bulk packaging is available or repackaged Prescription Drugs.

4.16 Prescription Drugs dispensed to a Member by a pharmacist with the same legal residence as the Member; and/or a person who is a part of the Member's immediate family, including self, spouse, brother, sister, parent, step-parent, child or step-child.

4.17 Prescription Drugs prescribed to a Member by a Prescribing Provider with the same legal residence as the Member; and/or a person who is a part of the Member's immediate family, including self, spouse, brother, sister, parent, step-parent, child or step-child.

4.18 Prescription Drugs related to the treatment of a non-Covered Service as further described in the EOC (e.g., dental services).

4.19 Prescription Drugs determined by Us to be not Medically Necessary or that do not meet our utilization management criteria. The Health Plan reserves the right to require medical Prior Authorization for selected drugs before providing Coverage.

4.20 Prescription Drugs that are Experimental or Investigational, including, but not limited to, FDA approved drugs prescribed for an off-label use whose effectiveness is unproven based on clinical evidence reported in Peer-Reviewed Medical Literature, (except as required by state law or recognized for treatment of the indication in at least one standard reference compendium); drugs labeled "Caution-limited by Federal Law to Investigational Use"; drugs prescribed at investigational doses; or drugs with no FDA approved indications and drugs given as a part of a study. Although a service, supply, equipment, drug or procedure is approved for a diagnosis, disorder or condition, it may be considered Experimental or investigational for a different diagnosis, disorder or condition and, therefore, be excluded from Coverage.

4.21 Prescription Drugs You are entitled to receive without charge under any Workers' Compensation law, occupational statute, or any law, or regulation of similar purpose.

4.22 Prescription Drugs used to treat chemical dependency and/or substance abuse.

4.23 Replacement for lost, destroyed or stolen Prescription Drugs.

4.24 Vitamins and minerals (both over-the-counter and legend), except legend prenatal vitamins, and liquid or chewable legend pediatric vitamins as specified on the Formulary. Coverage requires an order from a Prescribing Provider.

SECTION 5: DEFINITIONS

5.1 Ancillary Charge

A charge in addition to the Member Responsibility You are required to pay for a Prescription Drug which, through Your request or that of the Prescribing Provider, has been dispensed by the brand name, even though the Prescription Drug is subject to the Maximum Allowable Cost and covered at the generic product level. The Ancillary Charge, if any, will be the difference between the Plan's contracted price for the Non-Formulary or Formulary brand name drug and for the Generic Drug. You are responsible at the time of service for payment of the Ancillary Charge directly to the Participating Pharmacy. The Ancillary Charge is not a Covered charge and does not apply to any Deductible, Coinsurance, or Out-of-Pocket Maximum.

5.2 Copayment

The specified amount You will be charged by the pharmacy to dispense or refill any Prescription Drug.

5.3 Covered Drugs

Prescription Drugs prescribed by a Prescribing Provider and approved by Us, subject to the specifications listed in this Rider.

5.4 Dispensed Container

A Dispensed Container is the single unit of a Prescription Order or Refill when multiple units are included. If a Prescription Order or Refill is for multiple tubes, bottles, packets, or vials of a Prescription Drug, the cost sharing amount applies separately to each one of those Dispensed Containers.

5.5 Formulary

A list of specific generic and brand name Prescription Drugs and Specialty Drugs authorized for Coverage by the Health Plan. This list is subject to periodic review and modification at least annually by the Health Plan's Pharmacy and Therapeutics Committee. Since there may be more than one brand name of a Prescription Drug, not all brands of the same Prescription Drug (e.g., different manufacturers) may be included in the Formulary. The Formulary is available for review in the searchable Formulary on Our website www.chciowa.com or by contacting Customer Service at the telephone number on Your ID card. Please note: Inclusion of a drug within the Formulary does not guarantee that Your health care Provider will prescribe that drug for a particular medical condition or illness. Additionally, all drugs listed are not medically appropriate for all conditions. Because a drug is listed on the Formulary does not guarantee coverage for all conditions.

5.6 Formulary Prescription Drug

A Prescription Drug that appears on the Health Plan's Formulary.

5.7 Generic

A Prescription Drug prescribed by its generic and chemical name heading according to the principal ingredient(s) and approved by the Food and Drug Administration.

5.8 Maintenance Medication Pharmacy

A pharmacy (either retail or mail order) that dispenses Maintenance Medications pursuant to a ninety-three (93) day/cycle supply.

5.9 Maintenance Medication(s)

Prescription Drugs, designated by the Plan for chronic conditions (e.g., not intended for short term use) and not included on the mail-order exclusion list.

5.10 Maximum Allowable Cost

The price assigned to Prescription Drugs that will be Covered at the Generic product level. The price is subject to periodic review and modification by the Health Plan.

5.11 Member Responsibility

The dollar amount detailed under Prescription Drug Benefits which must be paid by You to a pharmacy providing a Prescription Drug Covered by this Rider.

5.12 Non-Formulary Prescription Drug

A Prescription Drug that is not on the Health Plan's list of Formulary Prescription Drugs.

5.13 Non-Participating Pharmacy

Any pharmacy that is not a Participating Pharmacy as defined herein.

5.14 Participating Pharmacy

A pharmacy licensed in the State in which it is located that has entered into a written contract with the Health Plan to provide services to the Health Plan's Members, or on whose behalf a written contract has been made with the Health Plan which is in effect at the time services are provided.

5.15 Prescribing Provider

Any person holding the degree of Doctor of Medicine, Doctor of Osteopathy, Doctor of Dental Medicine, or Doctor of Dental Surgery or any other provider who is duly licensed in the United States to prescribe medications in the ordinary course of his or her professional practice.

5.16 Prescription Drug(s)

Any medication or drug which:

5.16.1 Is provided for outpatient administration;

5.16.2 Has been approved by the Food and Drug Administration; and

5.16.3 Under federal or state law, is dispensed pursuant to a prescription order.

This definition of Prescription Drug includes some over-the-counter medications or disposable medical supplies (e.g., insulin and diabetic supplies), psychotherapeutic drugs used for treatment of mental illness, other than when administered in a hospital or provider's office, and a compound substance when it meets the Health Plan's criteria and the product is not available commercially.

5.17 Prescription Order or Refill

The authorization for a Prescription Drug issued by a Prescribing Provider who is duly licensed to make such an authorization in the ordinary course of his or her professional practice.

5.18 Prior Authorization

A process where the Health Plan or its designee determines, prior to dispensing, that a Prescription Order or Refill, otherwise Covered under this Rider, has been reviewed and, based upon information provided by the Prescribing Provider, the Prescription Order or Refill satisfies the requirements for Coverage. Please see 2.7 of the Benefit Information Section for more information.

5.19 Self-Administered Injectable Drug(s)

Self-Administered Injectable Prescription Drugs, as defined by the Health Plan, are commonly and customarily administered by the Member, and are available through a Specialty Pharmacy. Examples of Self-Administered Injectable Prescription Drugs include, but are not limited to, the following, multiple sclerosis agents, medically necessary growth hormones, colony stimulating factors given more than once monthly, chronic medications for hepatitis C, certain rheumatoid arthritis medications, certain injectable HIV drugs, certain osteoporosis agents, and heparin products.

Note: For definition purposes, other injectable drugs, that may be acquired through a retail pharmacy, are not considered Self-Administered Injectable Prescription Drugs, including, but not limited to, insulin, glucagon, bee sting kits, Imitrex and injectable contraceptives.

5.20 Specialty Drug

Those drugs listed on the Specialty Drug Formulary. Specialty Drugs are typically used to treat rare or complex disease. These drugs frequently require special handling, and close clinical monitoring and management.

5.21 Specialty Pharmacy

A pharmacy that is designated as a Specialty Pharmacy by the Health Plan for Specialty Drug and Self-Administered Injectable Drug Prescription Orders or Refills.

5.22 Step Therapy

Step Therapy is an automated form of Prior Authorization based on previous pharmaceutical treatment where a trial of an alternative medication is required prior to Coverage. Please see 2.7 of the Benefit Information Section for more information.

5.23 Value Formulary

Value Formulary Prescription Drugs are offered at no Copayment on a temporary basis to Members that are on or have recently received certain drug(s) and/or receive a new prescription for certain drug(s), as designated by the Health Plan to promote effective and efficient use of Prescription Drug Benefits. These Prescription Drugs are listed in an addendum to the Formulary, found on the Health Plan website, www.chciowa.com. The Formulary addendum will also identify the Health Plan's criteria applicable to the Value Formulary. The Formulary addendum may change from time to time without prior notice.

SECTION 6: CONDITIONS

6.1 The Health Plan and its designees will have the right to release any and all records concerning health care services that are necessary to implement and administer the terms of this Rider or for appropriate medical/pharmaceutical review or quality assessment.

6.2 The Health Plan will not be liable for any claim, injury, demand or judgment based on tort or other grounds (including warranty of drugs) arising out of or in connection with the sale, compounding, dispensing, manufacturing, or use of any Prescription Drug whether or not Covered under this Rider.

6.3 The Health Plan may utilize Prescription Drug rebates as a mechanism to reduce Prescription Drug costs. Member will not share in any retrospective volume-based discounts or rebates. However, such rebates will be considered, in the aggregate, in Health Plan's prospective premium calculations.

COVENTRY HEALTH CARE OF IOWA, INC.

CHIEF EXECUTIVE OFFICER

ROUTINE VISION CARE BENEFITS RIDER

This Rider is made a part of the Agreement.

This Rider is effective the later of the Group Effective Date/Group Renewal Date or the day You become insured under the Policy.

In the event of a conflict between this Rider and any other provision of the Policy, including the Evidence of Coverage, this Rider shall control. This Rider shall be subject to all provisions of the Agreement, including the Evidence of Coverage, not in conflict with this Rider.

Routine Vision Care Benefits

The following routine vision care services will be Covered as part of a Medically Necessary eye examination:

(a) a medical history;

(b) evaluation of visual acuity and need for corrective lenses;

(c) external examination of the eye;

(d) binocular measure;

(e) ophthalmoscopic examination;

(f) medication for dilating pupils and desensitizing the eyes for tonometry;

(g) prescribing lenses; and

(h) confirming the appropriateness of eyeglasses or contact lenses obtained under the prescription.

Eye examinations must be provided by a Participating Provider.

One eye examination will be Covered every twenty four (24) months. The Member may receive routine eye examinations more frequently only if Medically Necessary and approved in advance by Us.

If a Member previously was eligible for vision benefits through another Group and there has been no lapse of coverage, prior eye examinations will be applied to the visit limitations under this Rider. If there is a lapse in coverage, prior eye examinations will not be applied to the visit limitations under this Rider.

Covered Service	Member Responsibility
Routine Eye Examination	$10 Copayment

Exclusions

(a) contact lenses or corrective lenses, except for the first pair of corrective lenses following cataract surgery or corneal transplant;

(b) eyeglass frames;

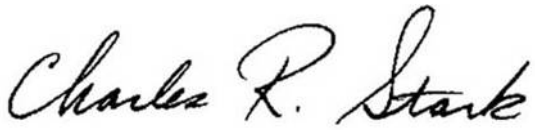
(c) Drugs or other medication not administered for the purpose of the vision examination;

(d) special or unusual procedures, including but not limited to, orthoptics, vision training, subnormal vision aids, rehabilitative services, tonography, or services which are Experimental or Investigational;

(e) services provided by a Non- Participating Provider, except for Emergency Services; and

(f) laser eye surgery or similar surgery done to treat refractive error.

COVENTRY HEALTH CARE OF IOWA, INC.



CHIEF EXECUTIVE OFFICER

COVENTRY
Health Care of Iowa, Inc.

MENTAL DISORDERS, SUBSTANCE-RELATED DISORDERS AND BIOLOGICALLY BASED MENTAL ILLNESS BENEFITS RIDER

This Rider is an addendum to the Evidence of Coverage (EOC). In case of any conflict between the terms or provisions of this Rider and the EOC, this Rider controls.

The benefits provided by this Rider become effective on the Member Effective Date or the date this Rider was purchased, whichever is later. The benefits provided by this Rider end when this Rider terminates or when Coverage under the Agreement ends.

All definitions, provisions, terms, limitations, exclusions, and conditions of the EOC apply to this Rider except to the extent such terms and conditions are explicitly superseded or modified by this Rider. Any capitalized terms used in this Rider and not otherwise defined herein will have the meaning set forth in the EOC. The plural or singular version of each defined word or phrase will apply the same definition.

The purpose of this Rider is to provide Covered Services for Medically Necessary and Treatable Mental Disorders, Substance-Related Disorders, and Biologically Based Mental Illnesses, subject to the terms, exclusions, limitations, and Member Responsibility listed below. The Provider, type and duration of treatment, and selection of facility or program may need to be Prior Authorized. **Please contact the Health Plan or Health Plan designee at the number listed on Your ID card prior to receipt of services. Failure to Prior Authorize when necessary may result in reduction or denial of benefits.**

We will review patient-specific symptoms to determine the appropriate level of care available under this Rider. To qualify for benefits, the patient must meet Our criteria for the applicable level of care. We will review patient symptoms with the Provider, along with medical records, to determine the level of benefits allowable.

SECTION 1: MENTAL DISORDERS, SUBSTANCE-RELATED DISORDERS AND BIOLOGICALLY BASED MENTAL ILLNESS BENEFITS

1.1 Table of Covered Services

	Member Responsibility	
Medically Necessary Covered Services	**In-Network**	**Out-of-Network**
All Services:	Refer to the corresponding medical Deductibles, Coinsurance, and/or Copayments listed in Your Schedule of Benefits for the type of service received	No Coverage

1.2 Member Responsibility

Payments You make for Covered Services described in the table above count toward any Deductible and Out-of-Pocket Maximum under the medical Health Plan. The Deductible and Out-of-Pocket Maximum amounts for the medical Health Plan are listed in Your Schedule of Benefits.

1.3 Out-of-Network Benefits

No Coverage will be provided for services received from an Out-of-Network Provider, except as specified in the EOC.

SECTION 2: DEFINITIONS

2.1 Custodial Care

Care, including, but not limited to, services, supplies or room and board primarily to maintain activities of daily living, self-care, and safety of the patient.

2.2 Diagnostic and Statistical Manual of Mental Disorders (DSM)

The most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association (APA).

2.3 Partial Hospitalization

Physician-directed, intensive or intermediate treatment in which the patient spends parts of each day in a licensed or certified facility or program. Partial Hospitalization may be used as an alternative to or as a transition from inpatient treatment. The patient continues to reside outside the healthcare facility, but commutes to the facility or treatment center up to seven (7) days a week. Treatment is provided by a team of behavioral health professionals. To be considered Partial Hospitalization, each daily session must last more than four (4), but less than twenty-four (24) hours.

2.4 Provider

A psychiatrist, psychologist, clinical social worker, professional counselor, master's prepared therapist, Physician assistant, nurse practitioner or addictionologist who is duly licensed by the state to provide services within the scope of their license.

2.5 Residential Treatment

Care received in a licensed, extended-stay facility that specializes in sub-acute care 24-hours-a-day. Care includes treatment with a range of diagnostic and therapeutic behavioral health services administered by a multidisciplinary team of Providers.

2.6 Treatable

An illness, injury or disorder We determine to be subject to clinical improvement with active medical or psychiatric intervention.

SECTION 3: LIMITATIONS

3.1 The following limits apply:

Medically Necessary Covered Services	Mental Disorders	Substance-Related Disorders	Biologically Based Mental Illness
All Services:	No maximum number of days, admissions or visits per Benefit Year apply, unless provided under the medical Health Plan listed in Your Schedule of Benefits		

SECTION 4: EXCLUSIONS

4.1 The following treatments and services are not Covered under this Rider:

4.1.1 Acupuncture, biofeedback, hypnotherapy, psychoanalysis or treatment of sleep disorders;

4.1.2 Alternative therapies, including, but not limited to, dance therapy or music therapy;

4.1.3 Conditions described in the Diagnostic and Statistical Manual of Mental Disorders (DSM) as "V" codes, including, but not limited to, relational problems, academic problems and phase-of-life problems;

4.1.4 Custodial Care;

4.1.5 Dementia and other organic mental disorders treatment, the treatment of delirium, amnesia or cognitive disorders without psychiatric complications;

4.1.6 Educational testing, developmental or training services, or academic counseling;

4.1.7 Experimental and Investigational treatments, drugs or devices, as defined by Us;

4.1.8 Marital or relationship counseling or religious counseling;

4.1.9 Mental retardation, developmental disorders and disorders relating to learning, motor skills, communication, feeding, and eating in early infancy and early childhood;

4.1.10 Methadone maintenance, halfway house, wilderness program, group home, or "boot camp";

4.1.11 Residential Treatment;

4.1.12 Services or supplies that We determine to not be Medically Necessary;

4.1.13 Services that are court ordered, a condition of probation or parole, at the employer's request, required for school, in connection with involuntary commitment, unless authorized by Us as Medically Necessary, or related to police detentions, and other similar proceedings;

4.1.14 Sexual deviations, disorders and dysfunction treatment including, but not limited to, sex counseling or therapy;

4.1.15 Treatment, therapies or drugs related to tobacco use cessation, caffeine use, gambling, weight reduction, or personal growth;

4.1.16 Treatment not related to an illness, injury or disorder, as defined in the most current Diagnostic and Statistical Manual of Mental Disorders (DSM);

4.1.17 Treatment related to antisocial personality disorder, conduct disorders or impulse disorders;

4.1.18 Treatment related to gender transformation services, regardless of any diagnosis of gender role disorientation or psychosexual orientation, including, but not limited to, any treatment or studies related to gender transformation;

4.1.19 Treatment that is not according to the approved and generally accepted medical or psychiatric practice prevailing at the time the Covered Service is ordered or treatment not subject to clinical improvement; or

4.1.20 Vocational or employment therapy, rehabilitation or counseling.

COVENTRY HEALTH CARE OF IOWA, INC.

CHIEF EXECUTIVE OFFICER